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of Health and Human Services



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MEDICARE

Reasonableness of Health Maintenance Organization Payments Not Assured



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

Human Resources Division

B-217802

March 7, 1989

The Honorable Don M. Newman
Acting Secretary of Health
and Human Services

Dear Mr. Secretary:

This report discusses the results of our review of the "adjusted community rate" (ACR) process, which is part of the payment-setting methodology for risk contract health maintenance organizations (HMOs). Our review showed that the process is not meeting its potential as a payment safeguard. The Health Care Financing Administration should issue more explicit instructions on the preparation of ACRs, and HMOs then should be required to abide by the instructions.

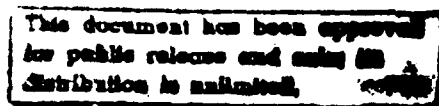
As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on action taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of the report to your Inspector General, the Administrator of the Health Care Financing Administration, and other interested parties.

This report was prepared under the direction of Michael Zimmerman, Director, Medicare and Medicaid Issues. Other major contributors are listed in appendix III.

Sincerely yours,

Lawrence H. Thompson
Assistant Comptroller General



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Executive Summary

Purpose

Under risk contracts, health maintenance organizations (HMOs) agree to provide all Medicare-covered services for a fixed monthly amount per beneficiary (capitation payment) and to experience a profit or loss depending on their cost to do so. Capitation payment rates to the HMO are set at 95 percent of what Medicare estimates its average costs would be in the fee-for-service sector for beneficiaries with similar demographic characteristics living in the same county.

Medicare law provides a payment safeguard to help ensure the accuracy of the methods used to calculate capitation rates. This safeguard, the adjusted community rate (ACR) process, is intended to prevent HMOs from retaining excessive profit from Medicare's payments. An HMO's ACR is its estimate of the premium it would receive from commercial enrollees with the same characteristics and benefit package as Medicare enrollees. If an HMO's ACR is lower than its estimated average Medicare payment rate, it must use the difference to provide additional benefits to Medicare enrollees or return the amount to Medicare. It may not keep the amount as excess profit.

Because of continuing concerns about the accuracy of Medicare's method of calculating capitation payments, GAO reviewed the ACR process to assess whether it was accomplishing its objective as a payment safeguard.

Background

While the process of calculating HMO payments is complex, the concept is simple. Annually, the Health Care Financing Administration (HCFA), which administers Medicare for the Department of Health and Human Services (HHS), computes and publishes "adjusted average per capita costs" (AAPCCs) for each U.S. county. AAPCCs are actuarial estimates of costs Medicare would incur, on average, in serving HMO enrollees if they remained in the fee-for-service sector. Payment rates for separate beneficiary categories (determined by demographic and other factors) then are set at 95 percent of the calculated AAPCC. HMO payments are the product of these AAPCC rates and the number of beneficiaries in each category.

The AAPCC-based payment is the maximum HCFA can reimburse a contractor HMO; the actual payment may be limited by the HMO's ACR. Each HMO, prior to its new contract year, calculates its ACR, using as a basis its commercial rates adjusted to account for differences in cost and use of services between Medicare and commercial enrollees. Once approved by HCFA, the HMO's ACR is compared with the average AAPCC-based payment

the HMO expects to receive from Medicare. If the expected payment is greater than the ACR, the difference, referred to as "savings," is to be used to reduce Medicare payments or improve the benefit package.

There are generally acknowledged limitations in the AAPCC method of paying HMOs. The preponderance of available research shows that HMOs tend to enroll healthier than average persons and that the AAPCC rate-setting method does not adequately adjust for this. To the extent this occurs in an HMO, overcompensation results. Given the limitations of the AAPCC methodology, the ACR process takes on added importance as a payment safeguard. (See p. 13.)

Results in Brief

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(HCFA's) process for reviewing, validating, and approving ACR submissions provides little assurance that the ACR process is meeting its payment safeguard objective. Judging from GAO's case studies of ACRs submitted by 4 HMOs and reviews of a random sample of ACRs submitted by 15 other HMOs, the process is susceptible to HMO manipulation and error. This is because HCFA does not always enforce its requirements that an HMO (1) use its own historic cost and utilization data as a basis for calculating its ACR, (2) follow the prescribed computational methods to account for differences between Medicare and commercial members' volume and cost of services, and (3) document the calculations.

HCFA, constrained in its review of HMOs' ACR submissions by the brief time it has to approve them, has not compensated by developing an effective monitoring program. Such a program could identify past and help avoid future problems. Also, HCFA lacks specific authority to recover funds it has paid erroneously to HMOs because of inaccurate ACRs. *Key words: Medicare; Cost Containment; payment; HMOs.*

Principal Findings

ACR Process Not Meeting Potential

The ACR process is not meeting its potential as a payment safeguard, judging from a review of ACRs submitted by 19 HMOs from 1985 through 1987. In 11 of the 19 HMOs, the ACR estimates were based in part on cost and utilization data other than the HMOs', even though HCFA's procedures generally do not permit the use of other data. Of the 11 HMOs, 4 were inconsistent in the source of the data, changing from one source to another from one year to the next with the effect of increasing the ACRs.

Overall, only 2 of the 19 HMOs appeared to have consistently followed all HCFA procedures in preparing their ACRs.

In one of GAO's four case studies where data were sufficient to determine the effects of deviations from HCFA's prescribed methods, the HMO's 1986 ACR was overstated by about \$6 million (15 percent). Overstating an ACR can result in understatement of amounts that must be returned to Medicare or beneficiaries. (See p. 21.)

Monitoring Should Increase

HCFA's process for reviewing and approving ACRs offers little assurance that they reasonably reflect the HMOs' own experience with Medicare. HCFA receives all HMOs' ACRs at about the same time and must approve them within a 45-day period. If an ACR is not approved during this period, the only option available is nonrenewal of the HMO's contract. Thus, HCFA has little time to verify the accuracy and reasonableness of the ACR and its alternative to approval is drastic. The short time frame sometimes forces HCFA to compromise and accept less support for the ACR submissions than might have been required had there been more time. (See p. 33.)

Periodic on-site reviews of HMOs to verify the support for approved ACR submissions would establish a baseline for reviewing and comparing future submissions. However, during the 3 years ended December 1987, HCFA made monitoring visits to only 29 percent of the 154 risk contract HMOs. Usually, these visits lasted 1 day and consisted primarily of discussions with HMO officials and reviews of policies and procedures. Such visits appeared to provide little information for future ACR reviews, as the scope of work was generally insufficient to verify the reasonableness of ACR submissions. (See p. 39.)

More Explicit Guidance Needed

Specifying a common format could enhance HCFA's ability to review and compare ACR submissions from year to year and from HMO to HMO, giving HCFA a way to gauge the reasonableness of the HMOs' estimates. HCFA's current instructions are not specific in delineating the format of HMOs' ACR submissions—i.e., categories of services that must be separately identified and services included in each category. As a result, ACRs have not been consistent in these areas. (See p. 36.)

Greater HMO Accountability Needed

HMOs are not required to certify the accuracy of the data underlying their ACR submissions. Also, once it approves an ACR, HCFA lacks a mechanism to retroactively adjust the HMO's payment rate even if it finds that the HMO's estimates were not based on accurate and current data and overpayment resulted. Short of instances involving fraud, HCFA has no specific authority to recover overpayments made because of inaccurate ACRs. HCFA's only clear recourse is to terminate the existing contract or not approve a new contract. Neither option is very practical because of potential adverse effects on Medicare enrollees. (See p. 41.)

Recommendations

GAO is recommending to the Secretary of HHS that he direct HCFA to exercise greater oversight and control over the ACR process by (1) clarifying its guidance on ACR preparation to better assure that ACR submissions are consistent and comparable between years and among HMOs; (2) increasing the frequency and scope of HMO site visits to verify ACR submissions; and (3) issuing regulations that require HMOs to certify their ACR submissions and specifically authorize HCFA to seek recoupment of any excess payments shown to have resulted from the HMO's use of data that were not accurate, current, or complete. (See p. 45.)

Agency Comments

HHS stated that, while it believes competitive forces make the ACR unnecessary, it recognizes that the ACR is a requirement that must be met. HHS agreed with GAO's recommendations and stated that HCFA had already taken some actions to strengthen and streamline the ACR process. (See p. 45.)

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Abbreviations

AAPCC	adjusted average per capita cost
ACR	adjusted community rate
ALOS	average length of stay
APR	adjusted payment rate
CMP	competitive medical plan
DRG	diagnosis related group
ESRD	end stage renal disease
FAR	Federal Acquisition Regulations
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Introduction

Health maintenance organizations (HMOs) that meet certain federal requirements may enter into risk contracts with Medicare. Under such contracts, HMOs agree to provide beneficiaries all Medicare-covered services for a fixed amount, or capitation rate, and realize a "profit"¹ or loss depending on their costs of providing covered services in relation to the fixed payment. Medicare sets the capitation payment to an HMO for each Medicare enrollee at 95 percent of what Medicare estimates its average costs would be in the fee-for-service sector for serving beneficiaries with similar demographic characteristics who reside in the same county. This arrangement was designed to save the Medicare program 5 percent over what it would cost if HMO enrollees remained in the fee-for-service sector.

Medicare requires HMOs to use an "adjusted community rate" (ACR) process as a means of controlling profit levels. The ACR process requires an HMO to estimate what it would charge a private member comparable to a Medicare beneficiary for the services covered under its Medicare contract. If an HMO's ACR is lower than its projected average Medicare capitation payment, the HMO must use the difference to benefit either Medicare enrollees by improving the benefit package or the program by reducing payments. Thus, the HMO should retain only the same level of profit for serving Medicare beneficiaries as for commercial enrollees.

Medicare and HMOs With Risk-Based Contracts

Medicare is a federal program (authorized effective July 1, 1966, by title XVIII of the Social Security Act) that assists most elderly aged 65 or older and certain disabled people in paying for their health care. The program is administered by the Health Care Financing Administration (HCFA), under the Department of Health and Human Services (HHS). It provides two basic forms of protection:

- **Part A, Hospital Insurance**, is financed primarily by social security payroll taxes and covers inpatient hospital services, posthospital care in skilled nursing facilities, hospice care, and care in patients' homes. In calendar year 1986, Part A covered about 31 million people and benefits amounted to about \$49.8 billion.
- **Part B, Supplemental Medical Insurance**, is a voluntary program financed by enrollee premiums (25 percent of total costs) and federal general revenues. It covers physician services and a variety of other

¹In this report, we use "profit" to refer to the amount that HMOs may retain. Some HMOs are non-profit organizations and may use excess revenues only for the purposes for which they received their tax exemption.

health care services, such as laboratory and outpatient hospital services. In calendar year 1986, Part B covered about 30.5 million individuals and benefits totaled about \$26.2 billion.

Since 1972, HMOs and other prepaid health providers meeting certain requirements have been authorized to serve Medicare beneficiaries on a prepaid basis under section 1876 of the Social Security Act. Under the Social Security Act Amendments of 1972 (P.L. 92-603), provisions for HMOs were quite restrictive, partly because of concerns over how to set accurate prospective rates. The 1972 amendments, which added section 1876 to the act, reflected concern that it might be impossible to calculate an actuarially equivalent payment rate that would assure that HMOs would not be overcompensated and profit excessively from Medicare.

Specifically, the Senate Committee on Finance report on the Social Security Amendments of 1972 stated the problem as follows:

"... If an HMO were to enroll relatively good risks (i.e., the younger and healthier Medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large 'windfalls' for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than Medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

"It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO."

Consequently, the 1972 amendments contained provisions designed to help assure Medicare would not pay HMOs more than it would pay under a fee-for-service arrangement and HMOs would not retain excessive profits. Under these provisions, HMOs were reimbursed on a prepaid basis, but were subject to retroactive adjustments based on their actual costs. For example, a risk-based HMO's allowed costs per member incurred during a contract year were compared with a capitated payment based on the "adjusted average per capita cost" (AAPCC) for all Medicare beneficiaries in the HMO's service area. If the HMO's costs were higher than the AAPCC-based payment, it had to absorb the loss or carry it over to be offset by future "savings" (i.e., the difference between the payment and the HMO's actual costs). If the HMO's costs were less than the AAPCC-based

payment, it shared the savings with Medicare on a 50-50 basis, but in no case could retain more than 10 percent of the payment as profit.

HMOs did not regard this risk-based option very favorably, apparently because HMO profits were limited and shared with Medicare, while losses had to be fully absorbed. For this and other reasons, only one HMO elected to contract with Medicare on a continuing basis under the risk-based option between 1972 and 1982, when the law changed again.

To encourage more risk-based contracts and increase Medicare beneficiaries' enrollment in risk-contract HMOs, the Congress in 1982 modified the Medicare reimbursement methods for such HMOs by enacting section 114 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (P.L. 97-248). As with the 1972 legislation, TEFRA authorized fixed per-beneficiary payments based on 95 percent of the AAPCC. But instead of HMOs sharing savings with Medicare, TEFRA permits them to retain all profits up to the level of profits earned on their non-Medicare business. Any profits above that amount must be used to provide Medicare beneficiaries with additional health benefits or reduced cost-sharing, or to reduce the Medicare payment rates.²

When TEFRA was enacted, concerns remained that the AAPCC methodology did not reflect the relative health care needs of Medicare beneficiaries who enrolled in the HMOs compared with beneficiaries in the Medicare fee-for-service system. Without proper adjustments to Medicare average per capita costs, payment rates could be too high or too low depending, in part, on whether HMOs attracted relatively more or less healthy beneficiaries. Therefore, TEFRA established the effective date of the HMO amendments as the later of (1) October 1, 1983, or (2) when the Secretary of HHS notified cognizant congressional committees that HHS was "reasonably certain" that an appropriate methodology had been developed for computing the AAPCC to assure actuarial equivalence of HMO and non-HMO members.

To gain experience with HMO risk-based reimbursement and other aspects of Medicare contracting with HMOs, HCFA contracted with 32 HMOs to operate demonstration projects between 1980 and 1984. Drawing on its experiences with these projects, in May 1984 HHS published the proposed regulations to implement section 114 of TEFRA. The Secretary

²HMOs may also elect to deposit the excess profits in a benefit stabilization fund. As discussed more fully on page 19, such deposits remain available to the HMO for up to 4 years to help it maintain benefit levels if expected profits fall below the levels allowed by HCFA.

provided the required notification to the congressional committees on January 7, 1985, on the appropriateness of the HMO reimbursement methodology, and issued the final regulations in January 1985, to be effective February 1, 1985.

Since HCFA published its TEFRA implementing regulations, the HMO program has grown rapidly. In 1985, Medicare payments to HMOs with risk-based contracts totaled about \$415 million; in calendar year 1986, these payments increased to about \$1.6 billion; and in calendar year 1987, rose to about \$2.3 billion. Over this period, Medicare enrollment in risk-based HMOs grew from about 304,400 in 1985 to over 910,000 in 1987. As of June 1, 1988, there were 138 HMOs or "competitive medical plans" (CMPs)¹ with Medicare risk contracts serving a total Medicare enrollment of about 1 million.

How HMO Payment Rates Are Set

While the process for calculating HMO capitated payments is complex, the concept is simple, as discussed below. HCFA annually calculates and publishes the AAPCC rates for Medicare beneficiaries in each U.S. county. AAPCC rates are computed separately for various categories of beneficiaries according to demographic and other factors. The AAPCC rates are actuarial estimates of what Medicare would incur, on average, for serving HMO enrollees in that county if they remained in the fee-for-service sector. The capitated payment rates for each beneficiary category are then set at 95 percent of the calculated AAPCC rates.

The AAPCC-based payment represents the maximum amount HCFA can pay an HMO; the actual amount is limited by an HMO's ACR. Prior to its new contract year, each risk contract HMO calculates its ACR—that is, what it would charge Medicare beneficiaries for Medicare covered services if they were commercial enrollees. The ACR is then compared with the average payment rate (APR) the HMO expects to receive from Medicare, based on AAPCC rates and the number and categories of enrolled beneficiaries. If the APR is greater than the ACR, the difference or savings is to be used to benefit Medicare enrollees or the program. HCFA must review and approve the ACR before it finalizes the HMO's contract.

¹CMPs are plans eligible to contract with HCFA for Medicare payments but not meeting the definition of HMOs in the Public Health Service Act. While there are several differences between CMPs and HMOs, a principal distinction is that HMOs must charge community rather than experience-based rates. Community rates are the same for similar individuals or families; experience-based rates may be based on the health care utilization experience of an enrollment group. We did not include any CMPs in our review, although the requirements for an ACR pertain to both HMOs and CMPs.

HMO Payments Based on Costs, Demographics

The methodology employed to set AAPCC rates is designed to assure actuarial equivalence—that is, the rates should reflect the payments Medicare would have made had the HMOs' members continued to obtain their medical services from the fee-for-service sector. To calculate the AAPCC rates, HCFA does the following:

1. Estimates the national average per capita Medicare costs for the payment year being developed.
2. Estimates county (or, for end stage renal disease [ESRD] enrollees, state) per capita costs, using a geographic adjustment factor based on the historical relationship over the most recent 5 years between county (or state) and national per capita costs. Thus, for the 5-year interval included in the projection, geographic areas that experienced low average per capita costs in the fee-for-service sector would have low HMO rates, while those with historically high average per capita costs would have high rates.
3. Using demographic adjustment factors, converts county per capita costs (with the per capita cost of prepaid health plans removed) into county rates. Data from the Current Medicare Survey¹ are used to calculate the demographic adjustment factors (as discussed below). HCFA then calculates separate Part A and Part B rates for Medicare aged, disabled, and ESRD beneficiaries.

Enrollees in each county are assigned to demographic classes based on their Medicare entitlement status (aged, disabled, or ESRD). For each entitlement status, they are placed in demographic cells based on age (subdivided into five groups), sex, and one of three categories: (1) institutionalized, (2) noninstitutionalized and Medicaid, or (3) noninstitutionalized and not Medicaid. This gives 30 demographic cells (5 ages X 2 sexes X 3 categories) for each of the entitlement statuses.

Adjusted Community Rate and Average Payment Rate

To help ensure that payment rates do not overcompensate HMOs for the services they offer, TEFRA provided for the ACR process. Before the start of a contract period, an HMO must develop and submit to HCFA for approval an estimate of the monthly per capita premiums it would charge, minus applicable Medicare copayments, to provide Medicare-covered services to its Medicare enrollees for the period. Beginning with

¹A survey of aged and disabled Medicare enrollees conducted annually from 1967 to 1977 to gather information on the use of Medicare-covered and noncovered health care services.

an estimate of the premium it would charge to provide such services to its non-Medicare enrollees, the HMO adjusts this rate to reflect differences in utilization and cost of services between Medicare and non-Medicare enrollees.

The ACR results in estimated revenue requirements (or a premium rate) for each service. For example, according to HCFA's HMO manual at least 13 separate premium rates are to be calculated for specified categories of services such as inpatient hospital, skilled nursing, home health care, physicians' services, and outpatient care. These individual premium rates then are added, and the resulting sum is the ACR. The ACR then is compared with the APR, and the difference between the two determines the HMO's "savings" or "loss"⁵ on the contract. Estimated losses are absorbed by the HMO, but the estimated savings must be returned to Medicare or program beneficiaries, as previously indicated. (See p. 17 for a further discussion of how the ACR is computed.)

AAPCC Does Not Adequately Predict Health Care Costs

For the HMO program to reasonably assure the realization of the Medicare savings TEFRA intended (or at least minimize the potential for cost increases), the AAPCC rates should be adjusted for the wide dispersion in the medical costs of the beneficiaries. Unless the AAPCC formula incorporates adequate adjusters to account for the differences in costs among beneficiaries, HMOs whose Medicare enrollment is not a true cross section of the general Medicare population could be substantially over- or undercompensated. For example, to the extent that HMOs disproportionately enroll beneficiaries who are expected to have low health care costs, overcompensation would result unless the AAPCC method included adjustments to account for this.

The current adjustments used in the AAPCC calculations, however, are not reliable as predictors of what enrollees would cost Medicare under the fee-for-service system. As discussed earlier, the AAPCC methodology incorporates adjusters for variations in expected health care expenditures due to differences in enrollees' (1) age, (2) sex, (3) institutional status (i.e., whether in a nursing home, as such enrollees generally incur substantially higher costs), and (4) Medicaid eligibility (these enrollees also usually incur higher costs). But these adjusters account for less than 1 percent of the differences in costs among Medicare beneficiaries,

⁵Loss in this context means profit levels less than those achieved by an HMO on its commercial lines of business. Savings means the expected balance remaining from Medicare revenues after the HMO pays for its members' use of Medicare-covered services and achieves its commercial rate of profit.

according to HCFA research.⁶ At least 20 percent of the cost difference is likely to be predictable, other research shows.⁷

This unpredictability is a problem when HMOs' Medicare enrollments are not representative of the general Medicare population, a condition referred to as biased selection. There is evidence that this is the case. In 1986, we reported⁸ that mortality rates for Medicare enrollees in the 27 HMOs covered by our review were only about 77 percent of expected mortality rates (adjusted for enrollees' age, sex, and institutional and Medicaid status). In a more recent analysis of HMO enrollees' mortality rates,⁹ a HCFA-funded study reported similar results—mortality rates in the 17 HMOs studied were 75 percent of those experienced in the general Medicare population. Consistent with our findings on mortality rates, other studies have concluded that HMOs tend to achieve favorable selection (enrolling healthier beneficiaries). These other studies' conclusions were reached by comparing the use of Medicare services by HMO enrollees prior to their enrollment with those used by fee-for-service control groups, or by comparing enrollees' perceived and functional health status with that of nonenrollee control groups.

HCFA has acknowledged the problem of biased selection in HMOs and the limitations of the AAPCC methodology to make appropriate adjustments. To increase the reliability of the AAPCC methodology as a predictor of fee-for-service costs, HCFA has proposed and has underway research directed at improving the adjusters used. Given the limitations of the current AAPCC and the preponderance of recent research showing that it produces payments biased toward overcompensating HMOs, the ACR takes on added importance. It helps ensure that Medicare and its beneficiaries get reasonable benefits for the price paid to contract HMOs.

⁶Lubitz, J., J. Beebe, and G. Riley, "Improving the Medicare HMO Payment Formula," Advances in Health Economics and Health Services Research, Vol. 6, R.M. Scheffler and L.F. Rossiter (eds.), JAI Press, 1986.

⁷Newhouse, Joseph P., Capitation and Medicare, Rand Corporation, 1986.

⁸Medicare: Issues Raised by Florida Health Maintenance Organization Demonstration (GAO/HRD-86-97, July 16, 1986).

⁹Mathematica Policy Research, Inc., Biased Selection in the Medicare Competitive Demonstrations, Mar. 1988.

Objectives, Scope, and Methodology

Because of continuing concerns about the adequacy of the AAPCC method for setting reasonable HMO payment rates, we reviewed the ACR process to assess the degree to which it effectively ensures a fairly priced package of benefits for Medicare enrollees. Specifically, we examined the extent to which HMOs were preparing their ACRs in accordance with HCFA's guidelines and instructions.

We performed our review at HCFA headquarters in Baltimore; in three of its regional offices—Chicago, Philadelphia, and Seattle; and at selected HMOs. At HCFA headquarters, we reviewed policies and procedures for preparing an ACR and discussed with HCFA officials the procedures and process used for reviewing and approving ACRs. We obtained similar information from HCFA's Chicago and Philadelphia regional offices, as these two offices had a high number of HMOs with risk contracts in their region (43 out of the 133 HMOs with risk contracts as of January 1, 1988). In the Seattle region, we primarily documented information on one of the four HMOs for which we performed an in-depth review of the HMO's ACR submissions (see pp. 21-24). We also reviewed pertinent sections of Medicare law and regulations.

To test the effectiveness and implementation of HCFA's ACR policies and procedures, we reviewed the calculations and supporting data for 47 ACRs prepared by 19 HMOs and approved by HCFA for contract years 1985-87. We sought to ascertain their computational accuracy, reasonableness, and conformance with HCFA guidelines. We judgmentally selected 4 of these HMOs for in-depth (or case study) review and randomly selected 15 other HMOs. Of the 47 ACRs we reviewed, 12 were prepared by the 4 case study HMOs, and 35 were prepared by the remaining 15 HMOs.

The 4 case study HMOs were chosen from 32 that had participated at some period between 1980 and 1984 in the HCFA HMO risk-based demonstration program that preceded the TEFRA program. We selected from these HMOs because each would have had at least 1 year of operating experience in the program by the time it prepared and submitted its first TEFRA risk contract ACRs to HCFA for review and approval. We reviewed these HMOs' records to determine if the submitted and approved ACRs were (1) prepared and supported by the HMOs' cost and utilization experience in serving Medicare beneficiaries, (2) computed in a consistent way from one year to the next, and (3) computed using HCFA's prescribed methods. We also compared the HMOs' ACR estimates with the

results of their Medicare operations during the year for which the estimate was made to gauge, where possible, the accuracy of the ACR forecast. The HMOs' ACR procedures and practices also were reviewed and compared to Medicare requirements.

To determine if any problems noted at the 4 HMOs also existed at other HMOs, we selected our random sample of 15 from the universe of 143 HMOs with TEFRA risk contracts as of September 30, 1986. The sample was stratified by Medicare enrollment with seven HMOs having 5,000 or more Medicare enrollees, four HMOs having from 2,000 to 4,999 Medicare enrollees, and four HMOs with Medicare enrollments under 2,000 members.¹⁰ We performed a desk review—that is, relied on the data submitted to and available in HCFA's records—to verify and gauge the reasonableness of these HMOs' ACR submissions. In desk reviewing these ACRs, we used the methods HCFA uses when it annually reviews and approves HMO ACR submissions. The results of the detailed review done at the 4 case study HMOs should not be considered representative of all HMOs with risk contracts, while those for the 15 HMOs randomly selected can be considered representative.

HCFA's HMO manual requires HMOs to break out 13 categories of services in calculating their ACR estimates. We limited our review of ACRs to five of these service categories—inpatient hospital, outpatient hospital, physician, home health, and skilled nursing care—that represent over 90 percent of Medicare's overall costs. As discussed later (see p. 36), however, HCFA is not specific about what services to include under these categories and HMOs did not always use the same terminology for their categories as HCFA nor consistently include the same services under each category. To achieve as much consistency as we could in reviewing the HMOs' ACRs, in some cases we regrouped an HMO's service categories to make them more comparable with HCFA's categories.

To obtain information on the reliability of the AAPCC rate-setting methodology, we reviewed the results of prior GAO work in this area and HCFA-sponsored research. This matter also was discussed with HCFA officials to obtain their views.

Our review was done between May 1986 and August 1988 in accordance with generally accepted government auditing standards.

¹⁰Of the 15 HMOs we sampled, 5 submitted ACRs for each of the 3 years; 9 submitted ACRs for 2 years, 1986 and 1987; and 1 HMO submitted ACRs for 1985 and 1986. The latter HMO dropped out of the program at the end of 1986.

The Adjusted Community Rate Process Not Functioning as Intended

HCFA's process for reviewing, validating, and approving adjusted community rate submissions provides little assurance that the ACR process is meeting its objectives as a reimbursement safeguard. Specifically, the process is subject to HMO manipulation and error. This is because HCFA does not always enforce its requirements that an HMO (1) use its own historic cost and utilization data as a basis for calculating its ACR and (2) follow the prescribed methods of adjusting its commercial rates to account for differences between Medicare and commercial members' volume and cost of services.

How the ACR Process Is Intended to Work

HCFA has established four steps an HMO must follow in developing its ACR:

1. Construct from its revenue requirements a base rate that is consistent with the premiums it charges its non-Medicare members and allocate the rate to specific service categories. For example, the HMO must break down its commercial rate into a minimum of 13 separate base rates for such services as inpatient hospital, home health, and skilled nursing care.
2. Construct an "initial rate" by adjusting the base rates to reflect Medicare-covered services. This involves, for example, subtracting from the commercial inpatient hospital rate amounts related to coverage for maternity benefits not applicable to aged Medicare beneficiaries.
3. Adjust the initial rate for differences between commercial and Medicare enrollees' utilization of services. Two components—volume and intensity—are involved. The volume adjustment accounts for differences in the amounts of service. For example, if Medicare beneficiaries use twice the number of inpatient hospital days as other enrollees, the volume adjustment for this service category would be 2. The intensity adjustment accounts for differences in resource consumption or costs. If, for instance, Medicare beneficiaries' average inpatient hospital costs per day are 90 percent of those incurred for other enrollees, the intensity adjustment for this service category would be .9. To convert the initial rate for inpatient hospital to the Medicare rate, the following formula is applied:

$$\text{Rate for Medicare enrollees' inpatient hospital care} = (\text{initial rate} \times \text{volume adjustment} \times \text{intensity adjustment})$$
4. Subtract an allowance for applicable Medicare deductibles and coinsurance, because these amounts are not paid by Medicare. HCFA requires

all HMOs to use the same amount, calculated for 1987 at \$38.51 per member per month.

Savings Determine HMO Premiums, Supplemental Services

The total services beneficiaries receive and the amount that Medicare will pay an HMO, subject to the AAPCC-based payment ceiling, are determined by any savings the HMO forecasts. The HMO must demonstrate to HCFA that savings, plus any premium it charges Medicare beneficiaries, are being applied to additional services above those normally covered by Medicare and that such services have a value commensurate with the savings. Otherwise, any savings are to be used to reduce Medicare payments.

As a practical matter, an HMO normally would be expected to use its savings (instead of returning them to Medicare) to offer lower premiums and/or additional services to beneficiaries to encourage enrollment in the HMO. Such encouragement is needed because joining an HMO often reduces beneficiaries' freedom of choice in selecting providers.¹ Consequently, most HMOs return the savings to Medicare beneficiaries in the form of additional benefits not covered by the regular Medicare program. These can include routine checkups, reduction or elimination of copayments and deductibles, and routine eye and hearing exams and corrective devices.

If an HMO's ACR results in savings that are higher than it needs to provide the supplemental services it wants to provide (and it chooses not to reduce beneficiary premiums or add additional services), it can deposit the excess in the benefit stabilization fund. TEFRA provided for this fund to give HMOs a means to conserve a portion of their savings for future use. The purpose is to avoid or mitigate the need for an HMO to reduce services during periods when profits on its Medicare business fall below those earned commercially. Once established, the stabilization fund is maintained by HCFA in a noninterest-bearing Treasury account available for use by the HMO for up to 4 years.

Because it is intended to prevent excessive fluctuations in the added benefits provided to beneficiaries in contract periods subsequent to those in which the monies are put into the fund, the fund may not be used in the period in which the money was withheld. To draw down its

¹ Medicare beneficiaries enrolled in HMOs are "locked in" to the HMO's service providers and can use services outside the HMO network only with prior approval by the HMO (except in emergencies or when services are urgently needed and the beneficiary is outside the HMO's service area).

account, the HMO must demonstrate to HCFA that it expects to need the funds to avoid reductions in additional benefits or increases in beneficiary premiums. When the time elapses, all amounts remaining in the fund revert to the Treasury and are credited to the hospital insurance trust fund.

Relatively few HMOs have used the fund—11 since the TEFRA risk contract program was implemented in April 1985. In all cases where applicable, monies were drawn down before the time period for doing so lapsed.

HMOs Required to Use Own Data and Document ACR Computations

As with any forecasting method, the ACR cannot be expected to be exact. However, it should be based on accurate data. As a starting point in developing ACR forecasts, the HMOs and HCFA should have available historic cost and use data to assess the HMOs' actual experience in serving Medicare enrollees. Absent such data, neither HCFA nor the HMO is in a good position to assess whether Medicare payments are reasonable. In some instances, an HMO's actual data may be unreliable for ACR forecasting because of the HMO's relatively low Medicare enrollments and/or limited experience under the Medicare program. But HCFA should be the final arbiter in these matters. Without having HMO-specific cost and use data available during its review of an ACR submission, however, HCFA would not be in a good position to make a judgment about whether and/or what alternative data sources could be used. Consequently, HCFA's policy is to require HMOs to base their ACRs on HMO-specific historic utilization and cost data and to allow deviations from this policy only for adequately justified and documented reasons.

The utilization factors (i.e., volume and intensity adjustments) used to convert the initial rates to Medicare rates must be accompanied by adequate supporting data, according to HCFA regulations (42 C.F.R. 417.594(c)(3)). HCFA's HMO manual (sections 5303.1 and 5305(B)) specifies the criteria needed to support utilization factors. Among these, the factors should (1) be based on the HMO's own experience, (2) not duplicate other utilization factors in the initial rate, and (3) be clearly described and justified with the HMO's ACR submissions to HCFA. For example, the HMO must show the source of the data (including underlying assumptions), the period for which the data were determined, the size of the Medicare and non-Medicare populations, and why the factor is the most appropriate one available. The manual also specifies that, except for its first year in the program, an HMO must use its own utilization experience

and cost data to estimate the revenue it will need to provide Medicare-covered services to Medicare beneficiaries.

HCFA's contracts with risk-based HMOs impose other requirements relating to ACRs. The HMOs must maintain and make available to HCFA on request books, records, documents, and other evidence of accounting procedures and practices used to (1) establish the component rates of the ACR for determining additional and supplementary benefits and (2) determine the base rates used in setting premiums for state insurance agency purposes. Furthermore, the burden of identifying and proving the basis of the ACR estimates falls on the submitting organization, as HCFA's HMO manual states (section 5303.1). The manual also says that

"... proof of the validity of an ACR depends upon the organization using reliable, consistent, accurate, and authentic records and furnishing HCFA with adequate supporting documentation. The order of priority in accepting proof on adjustments for volume and intensity of services will first require evidence from the HMO's experience (i.e., utilization data from the hospitals, physicians, and other health service entities the organization uses).

Such records and accounting systems are needed by an HMO, not only for computing the ACR, but to comply with other reporting requirements under the Public Health Service Act.² These reporting requirements are aimed at monitoring federally qualified HMOs' utilization rates and financial results to ascertain their compliance with financial solvency requirements. Through these other reporting requirements, HCFA is alerted to actual or potential financial solvency problems (i.e., if the reports identify HMO losses and/or higher-than-expected utilization rates).

Case Studies Demonstrate Need for Better Oversight

HMOs should prepare ACRs as accurately as practicable. If the ACR is overstated, beneficiaries will get less or pay more than they should for services offered and/or Medicare will pay more than it should. But if the ACR is understated, an HMO may not be able to continue providing its benefit package without incurring losses or reducing its overall profit margins.

In one of four HMOs we reviewed as case studies, deviations from program guidelines for five categories of service increased the ACR by \$6.1

²For example, under the Public Health Service Act's reporting requirements, an HMO must submit annual reports on financial performance and on the utilization of services by category of enrollment—i.e., Medicare, Medicaid, and commercial.

million or 15 percent. The four HMOs we selected (designated by us in this chapter as A, B, C, and D) had Medicare enrollments ranging from about 1,600 to 24,000 members and had been operating as Medicare risk-contractors for several years. All began their participation in the program during HCFA's demonstration projects. Consequently, each had the experience and time to develop the data and methods for preparing ACRs.

But in computing the ACRs, one or more of the HMOs did not always (1) use historic operating data, (2) use current and complete data to support adjustments to its initial rates, (3) apply data on a consistent basis in a given ACR submission or from one year's submission to another, or (4) follow HCFA regulations and guidelines for computing and/or applying volume and intensity adjustments. In the one HMO for which sufficient data were available for us to determine the effect (HMO A), these deviations from required or acceptable procedures increased the ACR by \$6.1 million (15 percent) for the five service categories we reviewed.

HMO A: Inappropriate Data Used to Compute ACR

This not-for-profit HMO, which operates in a number of states, is one of the largest in the country. Its management information system can produce detailed data on the use and cost of serving its various categories of enrollment. In fact, studies prepared using this HMO's data are among those that HCFA authorizes other HMOs to use in preparing ACRs, if the HMOs lack sufficient experience in serving Medicare beneficiaries to use their own data reliably. But in preparing its 1986 ACR, HMO A did not always use its own or the most current data available.

Overall, several factors resulted in overstatement of the total Medicare premium for this HMO. They included the use of other than its own data, computational error, and failure to apply appropriate adjustment factors to all categories of services included in the 1986 ACR. As a result, rather than receiving \$4.0 million less from Medicare than it would have from commercial enrollees, which the ACR forecasted, the HMO in our opinion probably should have forecasted \$2.1 million in excess profits. The effect was twofold:

- Had the HMO's 1986 ACR showed excess profits, HCFA would not have allowed, as it did in 1986, the HMO to withdraw its 1985 deposit of \$305,000 from the benefit stabilization fund.
- Had the HMO forecasted excess profits in 1986, it would have had to either (1) make additional payments into the stabilization fund,

(2) accept a reduced Medicare payment, or (3) reduce Medicare beneficiary premiums and/or provide additional services.

Intensity Factor Misstated for Hospital Care

Not using its own data to calculate its intensity factor adjustments for hospital inpatient and professional services accounted for about \$4.2 million of HMO A's potential \$6.1 million overstatement in its ACR for this category. Because the HMO owned its provider hospitals and did not receive claims for payment in the same manner that HMOs receive claims from independent hospitals, it did not use hospital claims to determine the appropriate intensity adjustment. However, for its 1983 operating year the HMO had developed such data, which it used in its 1985 ACR submission. This hospital cost data, obtained as a special effort under the risk-based demonstration project, had not been updated. The results of this special effort show that, on a per-day basis, Medicare members incurred 88.9 percent of the inpatient costs that the HMO's non-Medicare members incurred. For outpatient services, Medicare members incurred 42.1 percent of the costs incurred by non-Medicare members.

Not wishing to use its 1983 data or replicate its study, the HMO developed another method for calculating its hospital intensity adjustment for inpatient and professional services, using Medicare's diagnosis related groups (DRGs).³ This method produced a higher intensity factor—98 percent instead of 88.9 percent. But, apart from producing substantially different results than were achieved using the HMO's most recent actual data available, we believe the method was flawed.

Under this method, each of the HMO's Medicare and non-Medicare hospital discharges was classified according to one of Medicare's DRGs and assigned a HCFA-determined weight. The latter reflects the relative cost of hospital resources consumed in the fee-for-service sector for Medicare beneficiaries. Using this method, the HMO computed an average weighted

³The Social Security Amendments of 1983 established the current prospective payment system for Medicare reimbursement of inpatient hospital service. Under this system, payment rates (or prices) are set in advance for 472 diagnostic categories, known as diagnosis related groups. Each DRG is a set of diagnoses that (1) are expected to require the same level of hospital resources (length of stay, length of operation, supplies, etc.) to treat patients and (2) are clinically coherent. That is, they are similar from a clinical perspective for such things as patients' age, principal diagnosis, and/or surgical procedure. For payment purposes, each DRG is assigned a weight to reflect its resource usage. These DRG weights represent the average resources required to care for patients in each DRG relative to the national average amount of resources spent or consumed per hospital stay. Thus, cases in a DRG with a weight of 2.0 should, on average, require twice as many resources as the hospital's average case.

value of resources consumed by its Medicare and non-Medicare members. This value, based on Medicare experience only, reflected the average amount of resources consumed on a per-stay basis. Next, the HMO used Medicare's national average length of stay (ALOS), rather than its own data, to determine the resources consumed by each group on a daily basis. The HMO then based its hospital intensity adjustment on the ratio computed by dividing the resulting resources used by Medicare members by those used by non-Medicare members. As a result, Medicare members were shown to consume 98 percent of the resources of non-Medicare members.

Rather than using its own actual data on length of stays, HMO A used national Medicare DRG data to reflect its costs and resource use, and national Medicare ALOS data to produce daily averages. Had it used its 1985 ALOS data for both its Medicare and non-Medicare members, the hospital intensity factor would have been 81.2 percent instead of the 98 percent that resulted from its method. HMO officials said they used the national ALOS data to be consistent with the DRG weights that HCFA formulated using national data for the fee-for-service sector.

Given that it selected the DRG weight methodology, the HMO should have used its own average length-of-stay data. DRG values are a nationally based, relative weight of resources required for a particular medical procedure. Thus, using the HMO's own data would be necessary to adjust the national figures to better reflect the relative value of the resources consumed by its members. Medicare beneficiaries tend to have longer hospital stays than non-Medicare patients for a given diagnosis, and more costly services (e.g., surgery) tend to occur early in the stay. Consequently, beneficiaries' average costs per day would be expected to be less. Applying the 81.2 percent adjustment factor would have reduced the ACR value placed on hospital inpatient and professional services by about \$3.8 million and \$0.4 million, respectively.

Also, the HMO advocated the use of the ALOS method for its affiliated HMOs. In a March 1986 internal study prepared by its central office, the HMO reported to its affiliated HMOs that using Medicare national ALOS data produced a higher total intensity factor in all three of the operating areas where tested. The study considered but rejected, without explanation, the method that used HMO-specific ALOS data.

Moreover, HMO A's study showed that the affiliated HMOs in different areas of the country appeared to be using intensity factors based on other than their own plan's experience. For example, one of the HMO's

East Coast affiliates used a West Coast affiliate's 1986 intensity factor for its 1986 ACR. This is questionable, as it is contrary to HCFA's requirements that HMOs use their own data. In addition, West Coast Medicare members may be using services differently than those on the East Coast. The potential impact on the ACR estimate of using external data is apparent from a statement in the study that "... if [HMO X] were to use [HMO Y's] intensity factor, the per member/per month rate in the [HMO X] ACR would have been \$38 higher."

Problems relating to this HMO's calculations of inpatient hospital volume adjustments and other less significant problems also contributing to the potential overstatement of its 1986 ACR are summarized in appendix I.

In commenting on our draft report, HHS stated that it had reviewed its HMO A files and did not find sufficient information to agree or disagree with our findings. It plans to have further discussions with us and the HMO on this matter. HHS noted that HMO A waived a significant amount of the premium it could have charged.

In orally commenting on the draft, HMO A expressed concern about the reasonableness of our estimate of the HMO's overstatement of its 1986 ACR. Specifically, it said that if the DRG method was not acceptable, we should have used the HMO's method of calculating its 1985 ACR—that is, use the HMO's actual 1983 cost and use data to recalculate the ACR. Had we done so, the HMO's overstatement of its 1986 ACR would have been reduced from \$6.1 million to \$4.8 million. We did not do so because HCFA had approved the HMO's DRG method for the 1986 ACR and, without actual 1985 cost data, neither we nor HCFA had a basis for determining with certainty which ACR calculation would have been most reasonable. Consequently, we believe the preferred alternative was to use, as we did, the data contained in the HMO's 1986 approved ACR submission and make the adjustments to the ACR discussed above.

HMO B: Utilization Data Unavailable

Having participated in HCFA's demonstration project, this not-for-profit HMO converted to the risk contract program in April 1985. Medicare membership under the risk contract program ranged from 2,340 to about 9,770 members. Revenues in 1985 amounted to \$82.1 million, of which \$8.2 million was from Medicare's risk contract program. While HMO B had a system capable of collecting the utilization data needed to compute volume and intensity adjustment, HMO officials told us that problems in processing the data precluded it from doing so. As a result, HMO B used data from published sources to calculate the volume and

intensity adjustments for its 1985, 1986, and 1987 ACRs. Additionally, in its 1986 ACR it changed the sources of published data it used to calculate the volume and intensity adjustments. This had the effect of increasing the ACR.

Because of problems experienced with its automated claims processing system, HMO B lacked 1984 operating data when it prepared its 1985 ACR submission and was unable to generate it for us. Therefore, we could not assess the reasonableness of the published data it used. The HMO prepared for us, however, a statement of its 1985 Medicare operating results. By comparing this data with its 1985 ACR estimated revenue requirements, we found the estimates exceeded actual costs for all but one of the service categories we reviewed. For providing inpatient and outpatient hospital services, for example, the ACR revenue estimate was \$136.90 per member per month and the cost of providing these services, \$111.25. This represents a difference of \$25.65 per member/per month (18.7 percent), or about \$705,300 for 1985.

As the ACR computations include an allowance for profit or surplus, some of this difference between the ACR and actual costs reflects an allowance for surplus comparable to that retained on the HMO's commercial business. Because this allowance for surplus is not identified separately in HMOs' ACR computations,¹ we could not determine precisely how accurate the ACR forecast was. However, the HMO's consolidated financial statements (including operating results of both Medicare and non-Medicare members) showed an overall surplus of 2 percent in 1984 and 7.6 percent for 1985.

In preparing its 1986 ACR, the HMO again reported to HCFA that because of continuing claims processing problems, it had no actual Medicare data on which to base its ACR. Consequently, the HMO continued to use data from other sources. Between years, however, it changed the sources of published data it used to compute the volume and intensity adjustments in four of the five ACR categories we reviewed. No explanation was given HCFA nor shown in the ACR as to why the HMO believed it was appropriate to change published data sources. The result, however, of changing data sources was an increase in the ACR for 1986. For example, by changing the source of published data used to compute the estimate for services under the inpatient hospital category, HMO B increased the ACR estimate over its 1985 estimate by \$9.78 or 8 percent. Also, because its base rate

¹Under HCFA's ACR methodology, profit or surplus is built into the base rates and not separately identified. These base rates, as discussed on page 18, are then adjusted to derive the ACR.

for the service increased between 1985 and 1986, the HMO increased its ACR estimate for this service by an additional \$11.96.

In commenting on our draft report, HHS stated that the HMO was allowed to switch data sources between 1985 and 1986 because the new study it selected as a data source was more current and appropriate. Both studies used by the HMO (the old and the new) were included on the list of HHS studies approved for this purpose, we were told. However, as the HMO presented no actual cost and use data to us, or to HCFA at the time the HMO submitted its 1985 or 1986 ACRs, there is no basis for concluding that one data source would have been more or less appropriate than another. The point of this example is that HMOs have substantial discretion to select whatever data source produces results most acceptable to them. Consequently, absent actual HMO-specific data, the reasonableness of ACR submissions cannot be reliably assessed and an HMO's ACR is subject to manipulation.

HMO C: Use of HMO Data Produces Accurate ACR

This for-profit HMO participated in HCFA's demonstration project, converting to the risk contract program on April 1, 1985. Medicare membership under the risk contract program ranged from about 5,570 to 7,590. Revenues in 1985 amounted to \$65.1 million, of which \$9.8 million was from the risk contract program. The HMO used its own utilization data to compute its utilization adjustment factors for the three ACRs we reviewed.

To determine the reliability of its 1985 ACR revenue estimate prepared from its own data, we compared the HMO's estimate to the actual cost to provide the services. As in the case of HMO B, because there is no explicit HCFA requirement to identify profit, we could not assess precisely how accurate the ACR revenue requirement forecast was, but in each category of service reviewed the forecasted amounts exceed actual costs. For example, in the largest ACR service category, which for this HMO included inpatient hospital and skilled nursing care services, the HMO forecasted revenue requirements of \$104.22. Actual costs for the 1985 contract year totaled \$87.42—a 16.1 percent difference.

Because HMO C used its 1985 operating data in preparing the 1986 ACR, to the extent that this forecast may have been higher or lower than warranted by the HMO's commercial profit rate, both the HMO and HCFA had the information on which to judge whether forecasting adjustments should be made. For the inpatient hospital and skilled nursing care service categories, such adjustments were made. Using its 1985 experience,

HMO C reduced the volume and intensity factors for these categories in its 1986 ACR submission with the effect of reducing, from \$104.22 to \$97.48 (6.4 percent), the resultant revenue requirement estimate for inpatient hospital and skilled nursing care. Overall, between 1985 and 1986 the HMO's ACR increased about 3.2 percent, from \$193.03 to \$199.16. The HMO's actual costs to provide the required Medicare services in 1986 were not available at the time we visited the HMO. From our review, it appears that the HMO prepared its ACRs in accordance with HCFA requirements.

HMO D: Adequate Data System Lacking

This not-for-profit HMO also participated in HCFA's demonstration project and converted to the risk contract program in April 1985. The HMO's Medicare membership under the program ranged from about 270 in April 1985 to 1,620 in June 1987. Although the HMO had total (Medicare and non-Medicare) revenues in 1985 of \$32.1 million, it incurred an operating loss of about \$2.2 million. From April through December 1985, HCFA's payments to the HMO amounted to \$1.2 million.

HMO D used data from published sources to calculate its volume and intensity adjustments for the five service categories we reviewed over the 3 years it was in the risk contract program. According to an HMO official, the HMO could not use its own utilization data because some of the data accumulated in its system were incomplete and all utilization data had not been accumulated. The HMO's data system was primarily a manual system with only limited computer capabilities, and some of its centers at which services were provided had submitted incomplete information to include in the database. In addition, the actuary who prepared the HMO's ACRs indicated that basing utilization on an average of a small Medicare population would make any analysis subject to extreme fluctuation.

Because HMO D did not maintain a separate accounting of costs for its Medicare and private business, we could not use its data to compute volume and intensity factors to compare its ACR estimate to one based on the HMO's experiences. As a result, we were unable to determine whether the revenue estimate prepared using published data represented a fair price for Medicare to pay for the services beneficiaries received. HCFA imposes no specific requirements on an HMO concerning the capabilities

of its management information systems.⁵ But under the Public Health Service Act's reporting requirements, HCFA does require HMOs to submit certain financial and utilization reports. These are categorized by enrollment, i.e., Medicaid, Medicare, or commercial. The reports are not audited for completeness or accuracy, and sometimes data are not separated by category of enrollment.

Sampling of ACR Submissions: Documentation Problems Indicated

To supplement the data we gathered in our four case studies, we performed a desk review of ACRs submitted by a sample of 15 HMOs. Only one of the HMOs consistently followed HCFA's regulations and guidelines in preparing its 1985, 1986, and 1987 ACRs, our reviews showed. For the other 14 HMOs, deviations from HCFA's requirements occurred because the HMOs, in one or more of their ACR submissions,

- used other than HMO-specific data to compute at least some of the volume and intensity adjustments without documented justification in the submissions,
- switched data sources from one year to the next without documented justification, or
- did not apply required volume and/or intensity adjustments in one or more service categories.

Because of these deviations from HCFA requirements, the HMOs' ACR submissions often did not include all the information HCFA required to assess whether the ACRs were reasonable. Where data were available for us to determine the effect of these deviations, they usually increased the estimated revenue requirement for the particular service category.

Use of Non-HMO Data

As with the four case studies previously discussed, we found in our sampled HMOs that HCFA did not always enforce its requirements regarding the use of HMO-specific data. Also, some HMOs changed from using one published source of data to another from one year to the next without justifying and documenting the rationale as required by HCFA instructions.

Eight of the 15 HMOs sampled did not always use their own specific data to prepare one or more of the 1985-87 ACRs we reviewed. Each of these

⁵HCFA will enter into Medicare contracts only with eligible HMOs. HCFA determines eligibility by applying a series of qualifying conditions pertaining to the HMO. Among these are operating experience, enrollment, range of services provided, effectiveness of quality assurance program, and a determination that the HMO meets all applicable requirements of the law and regulations.

HMOs had been a Medicare contractor for at least 2 years and contrary to HCFA instructions used data other than their own after their first year of operations. Of the 8 HMOs, 2 used different sources of published utilization data from one year to the next to calculate their ACR estimates. Neither submitted justification for this, so we were unable to determine from our desk review their rationale for changing published data sources.

Changing studies from one period to the next did, however, increase the HMOs' ACRs. For example, one HMO changed the published source of utilization data it used to calculate its volume and intensity adjustments for the inpatient hospital service category from 1986 to 1987. Changing the data source increased the utilization adjustment factor by 33 percent and the HMO's ACR estimate for this service by \$17.90 per member/per month, or about \$88,500 a year, based on the HMO's June 1987 Medicare enrollment. This occurred even though the initial rate (i.e., the commercial premium for this service) decreased over this time period, as table 2.1 shows.

Table 2.1: Effect of Changing Data Sources for Inpatient Hospital Service Adjustment (Sample HMO, 1986-87)

Year	Initial monthly rate ^a	Utilization factor	Estimated revenue to provide the service
1986	\$16.29	4.53	\$73.79
1987	\$15.18	6.04	\$91.69
Change in ACR estimate			\$17.90

^aThe HMO's commercial rate adjusted for the required Medicare-covered services.

Requirements Not Followed in Applying Volume and Intensity Adjustments

In preparing its ACR estimate, an HMO must adjust its commercial rates to reflect the use of medical services by its Medicare population. Both a volume and an intensity adjustment must be used to calculate the utilization factor, according to HCFA's HMO manual (ch. 3, sec. 5305[c]).

Two of the 15 HMOs (representing 5 of the 35 ACRs) used both a volume and an intensity component to calculate the utilization factors for all of the five service categories we reviewed for a 3-year period. In the case of 8 HMOs, the ACR submissions did not provide information that would allow us to determine whether both a volume and an intensity adjustment were used. Where we could determine what was used,

- 8 HMOs used only a volume adjustment for at least one service category, and

- 4 HMOs used only an intensity adjustment for at least one service category.

To illustrate the nature of the deviations from the HMO manual, one HMO in its 1985 ACR estimate used both a volume and intensity component to calculate the utilization factor used to increase its commercial inpatient hospital rate to the Medicare estimate. However, the HMO was inconsistent in applying the required factors for three of the remaining four service categories we reviewed, that is:

- For the outpatient hospital category, the HMO used only a volume component to calculate its utilization factor.
- For the skilled nursing category, neither a volume nor an intensity component was used.
- For the physician service category, the HMO used a factor that was not sufficiently documented for us to determine its purpose (i.e., volume or intensity).

Also, we could identify no category for "home health" services, which according to HCFA's manual, should be broken out separately in the ACR submission. We were unable to determine from the documentation submitted with the ACR the effect of these deviations from HCFA requirements on the HMO's ACR estimate. But when neither volume nor intensity adjustments are used, the estimate for the ACR category involved cannot be presumed to have been calculated correctly. (An example of the effect of not using the intensity factor is shown on p. 35.)

In addition, 5 of the 13 HMOs (involving 5 ACRs) were inconsistent in the way they calculated the utilization factor from one year to the next. For example,

- 1 HMO changed from using only a volume adjustment to using only an intensity adjustment,
- 2 HMOs changed from using both a volume and an intensity adjustment to using only one, and
- 2 HMOs changed from making a utilization adjustment to making no adjustment.

These changes usually resulted in an increase in the ACR estimate for the categories involved over what it would have been had the HMO not changed its calculation methods. For example, one HMO changed the method it used to calculate the utilization factor in its 1986 ACR for two categories—skilled nursing and outpatient hospital services. The effect

was to increase the ACR estimate between 1985 and 1986 for the two categories by \$6.03 per enrollee per month. Specifically, in 1985 this HMO did not adjust for differences in utilization to calculate its Medicare estimate for the skilled nursing services, and used only a volume adjustment to calculate its outpatient hospital estimate. In 1986, the HMO used only a volume adjustment to calculate the utilization factor for the skilled nursing category. It also changed from using only a volume adjustment to using only an intensity adjustment to calculate the utilization factor for the outpatient hospital category. These two changes increased the utilization factor for skilled nursing from 1 to 6.85 and for outpatient hospital from 4.05 to 4.14. Given the HMO's December 1986 enrollment, this increased the ACR estimate by over \$75,500 for the year.

As long as an HMO submits supporting documentation on the utilization factors it is using (i.e., at least citing the source), a HCFA official told us, the auditor will not question or require that other data be used. This is true regardless of whether the data are from other sources or the HMO's own utilization data.

Some ACR Estimates Not Adequately Supported

For HCFA to determine the validity of the ACR estimate, the ACR submission must contain adequate documentation. The HCFA HMO manual (sec. 5303.1) requires that the utilization adjustments used in each ACR be adequately documented. The HMO must show the source of the data, including the assumptions underlying the calculations, and state in the ACR why the factors being used are the most appropriate available. The burden of proof of the validity of the factors used rests with the HMO, the manual states.

Generally, we considered an ACR proposal to be inadequately documented if (1) the source data referred to were not included with the proposal or (2) documentation included with the proposal was inadequate for us to verify the calculations used to derive the estimated rate. For the five service categories reviewed, 11 of the 15 HMOs submitted 23 ACRs with revenue estimates that were inadequately documented. The ACR submissions lacked adequate documentation concerning the source of utilization data used, the methodology used when HMOs used their own data, and the calculations used to arrive at an estimated rate.

For example, HCFA notified one HMO that its ACR did not contain adequate supporting documentation and requested additional data concerning the base rates and the volume and intensity adjustments. Although the HMO

submitted a revised ACR that contained additional supporting documentation, it was not adequate, and HCFA again requested more data pertaining to the same areas as in its original request. The HMO submitted a third ACR containing additional documentation. HCFA reviewed and approved this ACR. However, our review of this ACR showed that the HMO still had not adequately documented all sources of data used to calculate the utilization adjustments in its ACR estimates.

Conclusions

As with any forecast, the ACR cannot be expected to be perfectly accurate. However, HCFA can place itself in the best position for assessing the reasonableness of ACR estimates in several ways. It can adhere to its policy that requires HMOs to use their own historic utilization and cost data and specified methods of computing their ACRs, and can allow HMOs to deviate from this policy only for adequately justified and documented reasons. When utilization data from other sources are permitted without an adequately supported rationale, there is a risk that the ACR may be over- or understated. Furthermore, when the calculations, data sources, and assumptions used in calculating an HMO's ACR are not adequately documented, HCFA cannot reasonably assure itself that the HMO's ACR is justified. In the one case study (HMO C) where the HMO followed HCFA's prescribed procedures, both HCFA and the HMO were in a good position to judge the reasonableness of ACR submissions.

Our review of 19 HMOs' ACR submissions, however, has shown that HCFA was not always enforcing its requirements that ACRs be based on HMO-specific data, accompanied by adequate documentation, and computed in accordance with approved methods. The effect of these deviations from HCFA guidelines (where we had sufficient data to determine it) often was to increase the HMOs' ACRs.

HCFA should more consistently require HMOs to comply with approved methods for calculating and documenting their ACRs. This will require a different and more aggressive oversight and review approach than that currently in place at HCFA for reviewing and approving ACRs. Limitations in HCFA's current approach and recommendations that could assist HCFA in helping assure the reasonableness of ACR submissions are the subject of the following chapter.

Better Strategy to Verify and Approve ACRs Needed

HCFA's verification and approval of adjusted community rate submissions offer little assurance that they are reasonable in relation to the HMOs' historic cost and utilization experience in serving Medicare beneficiaries. Consequently, the ACR process is not meeting its potential for helping assure that Medicare and the beneficiaries enrolled in risk-contract HMOs are receiving the service coverage warranted by the payments made to the HMOs. HCFA should adopt a more aggressive strategy for verifying the data supporting ACR submissions. Among other things, it should

- consistently enforce its requirement that HMOs develop plan-specific internal cost and utilization data and use them to develop and support their ACR computations;
- develop and require the use of a common format for ACR submissions; and
- conduct periodic audits at the HMOs to verify that they are fulfilling Medicare requirements regarding ACR submissions.

Additionally, HMOs should be made more accountable to HCFA for the accuracy and reasonableness of ACR submissions. In this regard, HMOs should be required to certify the accuracy of their ACRs. If an ACR is found to be excessive because the HMO used unauthorized methods or data (without receiving approval from HCFA to do so), the HMO should be required to make restitution to Medicare and/or the affected beneficiaries.

Time Constraints Work Against Substantive Review

A short review time for ACRs sometimes forces HCFA to compromise and accept less in the way of support than probably would be acceptable were there more time to require additional information from the HMO. HMOs are required to submit their ACRs for review and approval at least 45 days before the start of the contract year—usually January 1 of each year. The ACR must be approved prior to the new contract period so the HMO can advise beneficiaries of the premiums required and benefits provided. Thus, HCFA must either approve the ACR in the time available or not renew the HMO's contract. With all HMOs submitting their ACRs at about the same time, HCFA is under a heavy workload and tight time constraints. Further, these time constraints are exacerbated because many HMOs submit their ACRs late, according to HCFA officials.

Efforts were made in 1987 to encourage timely submission of ACRs, according to a HCFA official, who advised that HCFA is currently reviewing options for assuring timely submissions in 1988. HCFA also is considering how to deal with HMOs that do not submit their ACRs on time, as providing additional time for the reviews is not considered practical.

Process Prone to Error

HCFA's Office of Prepaid Health Care monitors ACRs for compliance with Medicare laws and regulations. This responsibility includes the review and approval of each HMO's ACR estimates for each contract year.

HCFA must provide HMOs with the rates of payment for each class of Medicare enrollees no later than 90 days before the beginning of the calendar year, according to HCFA's HMO manual (sec. 5002). HMOs generally take about 45 days to complete their ACRs after receiving the rates, HCFA officials said. This leaves HCFA about 45 days to review the HMOs' ACRs and supporting documentation. In November/December 1986 and 1987, HCFA had to review 139 and 133 ACRs, respectively, within the 45-day period.

HCFA's reviews prior to approval are limited to desk reviews in which the reviewers complete a check list of items for each ACR. Two such lists have been used—a long and a short form. The long form, with 44 items to be reviewed, was used primarily for the 1985 and 1986 ACRs. A shorter form, with 12 items, was introduced in 1986 as a way of speeding up the review process for the 1987 ACRs. Although it reduced the thoroughness of the review, HCFA officials believe the shorter check list was needed because of the limited staff resources and time available to review and approve the ACRs.

To assess the accuracy of HCFA's desk reviews, we examined the checklists completed by HCFA staff for 36 of the 47 ACRs prepared by the 19 HMOs we covered. Often the checklists were not filled out correctly, and most lacked sufficient information to permit a meaningful supervisory review. Twenty-one checklists had one or more errors, as follows:

- 12 did not show whether all necessary supporting documentation had been submitted.
- 8 did not show whether all service categories were properly identified.
- 4 did not give the correct source for the statistical data used to calculate the volume and intensity adjustment factors.

Given the short time frame, we believe that HCFA staff would find it difficult to review and complete the ACRs more thoroughly than they were doing at the time of our study.

A HCFA official responsible for the ACR reviews told us he usually checked the reviewers' work to make sure that the HMO submitted all necessary information and that the submitted information was reviewed. He also checked the accuracy of the reviewer's calculations and looked at any information obtained from the HMOs in addition to the reviewer's completed check list. After his review was completed and any questions resolved, he said, the HMOs were sent their approval letters.

**Process May Force
Undesirable Compromises**

The brief time available for the review process also constrains HCFA's ability to resolve problems that are identified. One of our case studies (HMO A) provides an example of this.

There were significant problems in the way HMO A computed its inpatient hospital intensity factor for its 1986 ACR. While HCFA accepted this HMO's DRG-based method for computing the intensity adjustment for inpatient hospital services in its 1986 ACR, HCFA did not accept the method in the HMO's 1987 ACR. In a December 10, 1986, letter to the HMO, HCFA stated that the HMO should revise both the volume and intensity factors for inpatient hospital services to reflect the HMO's actual experience in treating Medicare enrollees. The HMO submitted a revised ACR proposal that based inpatient hospital volume on historical experience. To expedite the approval process, the HMO expressed a willingness to forego the intensity factor for hospital services. HCFA accepted this revised 1987 ACR proposal.

But without additional documentation on the acceptability of this change in methods, HCFA had no basis on which to determine whether the approved ACR properly reflected the relative cost of resources consumed by Medicare and non-Medicare enrollees. Foregoing an intensity factor had the same effect as using a factor of one (1.0), which was substantially higher than what this HMO experienced when it last used its actual operating data to compute its ACR. As discussed on page 22, for this HMO's 1985 ACR (the last year for which the HMO used its own data), the intensity adjustment for hospital inpatient and professional services was .889—about 11 percent lower than the amount accepted by HCFA. The intensity adjustment factor for outpatient hospital services for the 1985 ACR was 58 percent less than that accepted by HCFA. Use of these

factors would have increased the HMO's reported savings by \$3.73 million (based on forecasted Medicare enrollments in this HMO for 1988). This in turn could have reduced Medicare reimbursements to the HMO, and/or reduced beneficiary premiums or increased services.

More Explicit Guidance Needed on ACR Format

To help avoid problems in preparing and reviewing ACRs due to the complexity of the ACR process, the variations in HMO data systems, and the relatively short time available for review, HCFA's guidance to HMOs and reviewers should be explicit with regard to format and content of ACR submissions. HCFA's instructions to HMOs for preparing ACR proposals are not, however, as explicit as they could be.

An HMO's ACR submission (i.e., the volume and intensity adjustments used for each service category) should be compared with others' submissions and to its own past submissions. This could highlight significant differences or changes and alert HCFA staff to specific adjustment factors that may warrant more detailed review. HCFA recently has developed and implemented a method to readily compare ACR data across plans and years that offers promise for improving the ACR review process.

The new system's effectiveness is diminished, however, because the format HMOs use to prepare ACRs is inconsistent. Consequently, the ACR service categories used are not always consistent between one year's submission and another or between HMOs. This makes relevant ACR comparisons difficult and at times impossible. In addition, HCFA is not explicit in its guidance to HMOs on what health services to include in the various ACR service categories. Correcting this and requiring all HMOs to use the same format in preparing ACR submissions could resolve this problem.

HCFA has recognized the need for some consistency in HMOs' ACRs. Its HMO manual (sec. 5304.1 B [4]) states that an HMO must allocate its ACR estimate to service categories that include at least the following: inpatient hospital, skilled nursing, home health, physicians' services, outpatient hospital, outpatient X-ray, outpatient lab, out-of-plan emergency services, ambulance, and other Medicare, non-Medicare, working aged, and coordinated benefits. The guidelines are silent as to whether other categories are acceptable and specifically what health services should be included under each category.

Of the 47 ACRs we reviewed:

- 7 ACRs submitted by 3 HMOs properly identified the five service categories covered by our review (each of which is listed in HCFA's instructions).
- 21 ACRs submitted by 8 HMOs covered the five service categories but the categories were named differently.
- 19 ACRs submitted by 8 HMOs used four of the five service categories; we could not determine if the fifth category was used because of insufficient documentation in the ACR submissions.

If the various service categories and medical services included under each category are not uniform, comparison of an HMO's categories from one year to the next and to other HMOs is more difficult and at times impossible. To illustrate, one HMO used all five service categories in its 1986 ACR, but only three in its 1987 ACR. One of the two service categories not identified had been merged with another, and we could not identify the second category in the ACR submission because documentation was not available to do so.

Unless the health services included under the various categories are identical to services under the same categories in other ACRs, the validity of comparing the estimated rates is questionable. For example, an HMO's 1986 ACR rate for physician services' category was \$46.45. In 1987, the estimated rate for physician services was \$52.69. However, the estimated rate for 1987 included services for medical administration and utilization review, which were not included in the 1986 estimated rate. Further, the 1986 estimated rate included services for cardiology, urology, and dermatology, which were not specifically identified in the 1987 estimate.

In commenting on our draft report, HHS agreed with the desirability of using a common format for ACRs, but said this is not always practicable. HMOs now are required to prepare their ACRs in a similar format from year to year to facilitate comparisons. HHS stated that it had reviewed the ACRs covered by our review and noted 27 instances in which changes in the service categories could have taken place. It confirmed that in 59 percent of these cases changes had been made but believed the changes were not extensive. HHS agreed that each plan's service categories should be the same for each contract period and be available for comparison purposes so that unexpected changes can be noted and reviewed further. For this reason, HHS said, it has created an automated version of the ACR calculation format that will hasten the preparation of the ACRs

by the HMOs and make it possible for HCFA to complete its review and analysis work in a timely manner.

To facilitate its reviews of the 1988 ACRs, HCFA developed a database from the HMOs' approved 1987 ACRs. The information collected included initial rates, utilization adjustment factors, ACR rate component by service category, and the total approved amount of the ACR. This information was summarized and used to develop state and regional averages for each data component, including minimum and maximum ranges. But unless the health services included in each ACR service category remain the same from year to year and all HMOs use common categories, the value of comparing different years' ACRs for an HMO and an HMO's ACR with that of other HMOs remains questionable.

HCFA used this information to review the 1988 ACRs submitted by HMOs that had been in the TEFRA risk contract program at least 1 full year and had used published data to prepare the ACRs. The 1988 ACR components were compared with those of the database (i.e., initial rates, utilization factors, service category rate components, etc.). HCFA used the database amounts to determine the maximum allowable amount in instances where the ACR estimates were higher than those of the database. If the ACR estimate did not exceed the database amounts, the estimates were approved. When the service categories used were not comparable to those of the database, HCFA compared the total amount of the ACR with that of the database. Again, the amount shown in the database was considered the maximum allowable. If an HMO used its own data to develop its ACR, however, its estimates were allowed even if they exceeded the amounts shown in the database.

Auditing ACRs and Developing Recoupment Authority Would Increase HMO Accountability

HCFA's ACR review and approval process is constrained, as we discussed in chapter 2, because HMOs do not always (1) submit adequate documentation to support the ACRs, (2) use their own data in making the computations, and/or (3) follow HCFA guidelines in making ACR computations. While HCFA is sometimes able to identify and correct such problems, its short time frame for reviewing and approving ACRs can result in errors or compromises that, with more time, might not have been made. Given this environment, HCFA should periodically audit ACRs to assess the reasonableness of the HMOs' supporting documentation in comparison with the HMOs' internal records and accounting system reports.

By periodically auditing ACR submissions, HCFA could establish a baseline with which to compare future submissions. Such audits, however, cannot easily rectify past problems, only prevent future problems. This is because HCFA lacks clear authority to recover funds it overpaid because the HMO provided inaccurate data or used other data sources when its own data were or should have been available and used. In this regard, Medicare risk-based contracting differs from many other federal agencies' contracting authorities, which specifically provide for recoupment when contractors' data are subsequently found to be inaccurate, not current, or incomplete.

HCFA On-Site Verification of ACRs Limited

In addition to reviewing and approving ACR proposals, auditors from HCFA's Office of Financial Management visit risk contract HMOs to test and review the information used to prepare ACR proposals. Generally, the auditors spend a day at an HMO to obtain information necessary to complete a check list developed by HCFA. They also prepare a trip report that briefly discusses the work performed. It identifies, for example, HMO personnel contacted and meeting dates, and briefly describes the items reviewed.

HCFA's check list covers (1) verification of the base rate, (2) support for adjustments to the base rate, (3) support for the volume and intensity adjustments, (4) support for the value of additional or supplemental benefits offered, and (5) whether the HMO is accumulating its own utilization data for its next year's ACR estimate. While at the HMO, the auditor will obtain copies of financial statements, brochures describing benefits, policies and procedures, and approval letters from the state for premium rates charged.

These short monitoring visits, in our view, cannot be properly categorized as audits. HCFA plans to increase the frequency of such visits but has no plans to perform audits that would verify the accuracy and assess the reliability of the ACR computation.

From the beginning of the program in April 1985 through December 1987, HCFA has made 46 monitoring visits to risk contract HMOs, reviewing about 28.5 percent of the 154 HMO contractors.¹ From our review of 35 completed check lists and the trip reports, the auditors' visits appear to consist primarily of discussions with HMO officials and reviewing policies and procedures. The check lists do not indicate the specific data the

¹Two HMOs received two monitoring visits each.

auditor reviewed in responding to check list items nor the tests and/or analysis performed. Further, the reports do not explain the work performed by the auditor. For example, although 24 of the 35 reports stated that selected cost data were reviewed and/or tests performed, only 1 commented on the extent of the auditor's work. While many of the reports identified deficiencies, such as limitations in an HMO's system for producing reliable cost and use data, none stipulated the corrective actions HMOs had agreed to take as a result of the deficiencies.

HCFA has developed a new monitoring protocol to improve its oversight of risk-contractor HMOs—including their compliance with requirements for preparing ACRs—HCFA officials told us in August 1988. The protocol, to be implemented later this year, suggests that monitoring visits be scheduled early in the contract year so that the results from the visits will be available to officials who must approve contract renewals. It also requires that (1) the audit team report deficiencies an HMO must correct and (2) the HMO prepare a corrective action plan in response to deficiencies cited in the report.

The protocol appears to be a step in the right direction. But as implemented by HCFA, there will be few or no changes made in the scope of the ACR review and verification work done at the HMOs during the monitoring visits. Staffing and budgetary constraints prevent HCFA from doing more, HCFA officials told us in August 1988. In commenting on our draft report, HHS advised us that HCFA was re-examining its policy for on-site reviews to determine its usefulness under the present circumstances and what changes are needed to improve the effectiveness of the visits.

Also, HCFA officials told us that the ACR process does not warrant an additional level of verification. In fact, HCFA has proposed to eliminate the process. HCFA considers the ACR process administratively burdensome—both for HMOs and for itself—and of little utility. Competitive market forces, HCFA believes, will act as a safeguard against HMOs profiting excessively from the Medicare business. Under HCFA's reasoning, if an HMO profits excessively from its Medicare business, other HMOs over time will be encouraged to compete in the same market by offering more services or lower premiums, thereby forcing other HMOs to do the same. Additionally, Medicare beneficiaries also can purchase supplemental or "medigap" insurance as a alternative to joining an HMO to obtain such coverage. HCFA believes the availability of this supplemental coverage acts as a competitive restraint on HMOs. Consequently, in a legislative

proposal (referred to as the "Medicare Expanded Choice Act") submitted to the Congress in July 1987, HCFA requested elimination of the ACR process. As of December 1988, the proposal had not been acted on.

HMOs currently do face competitive pressures. Most Medicare beneficiaries either purchase or receive (as a retiree benefit) medigap insurance to help defray the costs of care not covered by Medicare. In establishing its benefit package and premiums, it is reasonable to expect that an HMO would consider the benefits and premiums of medigap insurers in their market areas. Charging too high a premium or providing too few services relative to medigap insurers would place the HMO at a competitive disadvantage in attracting and retaining enrollees. The issue then is whether such competition acts as a sufficient constraint on HMOs to make the ACR process unnecessary. HCFA officials told us they were aware of no research on this issue. However, our findings discussed in this report would suggest that to resolve this issue HCFA should first develop better assurances that HMOs are submitting reasonable ACRs. We believe it is only after this is done that the value of the ACR process can be assessed.

Also, the ACR process allows HCFA to fulfill a role as an informed and prudent purchaser in contracting with HMOs on behalf of Medicare and its beneficiaries. In the competitive marketplace, employers or employer-sponsored groups would typically be expected to fill this role in selecting plans for their represented employees. When there are competing HMOs in the area, employers or employer-sponsored groups can take advantage of this by electing to contract with the HMO offering the best deal in terms of premium and benefit package. HCFA, on the other hand, must contract with any HMO able to meet requirements. Absent the ACR process, HCFA would have no means of assuring itself that the price paid for the HMO's service package is reasonable in relation to the HMO's expected profit on such services. Given the acknowledged limitations of the AAPCC rate-setting process, it is particularly important that this capability be retained.

**Specific Authority to
Recoup Overpayments
Needed**

Payments to HMOs with risk contracts are made prospectively. Once HCFA approves an HMO's contract and the resulting benefit package, retroactive adjustments to recover funds generally cannot be made. Short of instances involving fraud,² HCFA's authority to recover overpayments

²Section 1877 of the Social Security Act imposes civil monetary penalties on anyone who intentionally misrepresents a material fact to HHS.

when it subsequently determines the HMC submitted an inaccurate or unrepresentative ACR is unclear because HHS has not promulgated regulations providing HCFA authority to do so. Currently, HCFA's only clearly authorized recourse is to not approve a new contract or terminate the existing contract. These options may not be practical, given the effects on the HMO and the beneficiaries enrolled.

In the ACR process, HCFA is in a position similar to other federal contracting agencies that depend on a contractor's cost and pricing data in establishing a price. Such cost and pricing data are used to ensure that contractors do not make excessive profits, the same purpose as the ACR process. Unlike other federal contractors, however, such HMOs are not required to certify that the data they submit are current, complete, and accurate nor to make restitution if the certification is subsequently found to be incorrect and an excessive payment has occurred.

This is because HHS exempted (under 42 C.F.R. 417.472 [d]) such HMOs from the Federal Acquisition Regulations (FAR). The FAR, which applies to most government acquisitions of goods and services, requires contractor certification and permits the contracting agency to recoup funds if the certification was incorrect and excessive payments resulted. Because the government relies on the data provided by the contractor, these requirements prevent the contractor from reaping a windfall in the event that the contractor has supplied inaccurate data.

Although TEFRA provided that HHS could enter into contracts with HMOs without regard to conflicting federal contract laws and regulations, we were unable to ascertain exactly why HHS exempted HMOs from these particular requirements. There are, however, several distinctions between contracting with risk contract HMOs to provide specified services to Medicare beneficiaries and other types of procurement generally made by other federal agencies. For example, FAR provides for competitive procurement through the use of sealed bidding and, in certain cases, the use of negotiated procurement. Because HHS contracts with any qualifying HMO, the competitive bidding aspects of the FAR would not apply to Medicare HMO risk contracts.

In any event, in other contractual settings where the use of the FAR is not appropriate HHS provides for contractors to certify their data and recoups overpayments. Health care providers such as home health agencies that are paid on a cost basis must submit cost reports that they certify as accurate and that HCFA uses as a basis for final payment. HCFA

can recoup overpayments resulting from inaccurate cost reports if it subsequently identifies errors in the reports.

A key distinction between HMOs and such cost-based providers is that risk contract HMOs are paid prospectively, while other providers are usually paid retrospectively. However, the reliance on data supplied by the contractor and the need for such data to be current, complete, and accurate is essentially the same whether the payment is made before or after a service is provided. The amount of payment is based on the supporting data, and payments are often made before the data can be verified. In neither case should the contractor receive a windfall because its payments were based on inaccurate data. A key difference between prospective and retrospective cost-based payment, however, is that prospective payments cannot be calculated as accurately as cost-based payments. Consequently, even if an HMO's approved ACR is subsequently found to have been overstated, recoupment would be warranted only if the data the HMO used were out-of-date, incomplete, or inaccurate, and this clearly caused the overpayment.

The current standard HMO contract used by HCFA incorporates by reference specific provisions of the FAR. These provisions, however, do not deal with the issues raised here, but instead relate to federal contractor requirements involving civil rights, equal employment opportunity, age discrimination, contracting with small business firms, etc.

HHS, in commenting on our draft report, agreed that certification of the ACRs by a health plan (HMO) official could add credence to the accuracy and reliability of the information provided. HHS stated that it is working with its General Counsel to determine if such a certification can be required and, if so, implemented prior to the next ACR cycle.

Conclusions

HCFA's process for reviewing and approving HMOs' ACR submissions offers little assurance that the ACR process is achieving its potential as a payment safeguard. HCFA should consistently enforce its procedures requiring that HMOs (1) use both volume and intensity adjustments to calculate utilization factors and (2) adequately document the basis for the utilization factors used. Many of the HMOs in our sample were not complying with the requirement that both a volume and an intensity adjustment be used in calculating factors for ACR service categories. When both adjustments are not used, the ACR will be less accurate in predicting revenues the HMO needs to provide its Medicare benefit package and profit. Further, when calculations used to adjust the HMO's commercial rates are in

adequately documented, HCFA cannot determine whether the assumptions and data used in the calculations are appropriate.

Additionally, HCFA should more consistently enforce its requirement that HMOs use their own data to compute the ACR. In several instances, HMOs with more than 1 year's experience used other than their own data. While some HMOs with small Medicare enrollments and/or limited experience in serving Medicare beneficiaries may not be able to use their own data reliably in preparing ACR forecasts, HCFA should be the final arbiter in these matters. To do so and to make informed judgments on what data sources are appropriate requires knowledge of the HMO's own results. Consequently, HCFA should revise its manual to specify under what circumstances alternative data sources will be approved. Such circumstances should not, however, include the inadequacy of an HMO's data systems to generate the necessary data. Having sufficient data is a requirement of their contracts with Medicare and also the Public Health Service Act. HMOs that can or will not provide HCFA with such data should be required to do so as a condition of retaining their Medicare contracts.

Also, while HCFA's HMO manual specifies certain categories of services be included in the ACRs, HMOs often do not use these categories. In addition, decisions on what services to include under these categories are left to the HMOs' discretion. To allow HCFA to compare an HMO's ACRs from one year to the next and with those of other HMOs, more specific guidance is needed on (1) the service categories to include in the ACR and (2) what is to be included under each service category.

Site visits also should include an evaluation of the ACR estimate against the HMO's records and accounting system reports so HCFA can assess the reliability of ACR estimates. Specifically, the auditor should compare the ACR estimate with the HMO's actual cost and utilization data available to the HMO when the estimate was prepared. The auditor should also examine for appropriateness the methodology used by the HMO to calculate its volume and intensity adjustment factors. While performing these tasks likely will extend the monitoring visit, the information to be developed is vital to HCFA's evaluation of the ACR process.

HHS exempted HMO risk contracts from the FAR. Therefore, HCFA lacks specific authority to make retroactive adjustments to recover funds if the ACR subsequently is found to have been based on data that were not current, complete, or accurate. Short of instances involving fraud, HCFA has no explicit authority to take action against an HMO submitting an

inaccurate ACR estimate other than terminating or not renewing its contract. Because HCFA has a brief time to review and approve ACRs, it must rely on the data HMOs submit. Consequently, HCFA should (1) require HMOs to certify the accuracy of the data used to compute ACRs and (2) incorporate in the HMOs' contracts provisions allowing HCFA to recover overpayments caused by data that HCFA subsequently finds to be inaccurate, not current, or incomplete.

Lastly, we do not agree with HCFA's position that the competitive market is a sufficient constraint on HMOs' pricing to warrant eliminating the ACR process. The ACR process arose out of concern that the AAPCC process may not be adequate in adjusting payment rates to account for differences between the general Medicare population and those enrolled in HMOs. Such concerns still exist. Also, before the efficacy of the ACR process can be judged, we believe HCFA needs to first develop better assurances that HMOs are submitting reasonable ACRs.

Recommendations to the Secretary of HHS

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to revise its instructions to HMOs on preparing ACR submissions to

- require the use of a standardized ACR submission,
- require HMOs to use both volume and intensity adjustments to calculate utilization factors and adequately document the basis for the factors used, and
- stipulate the conditions under which HMOs will be permitted to use cost and utilization data other than their own for computing ACRs and establish a requirement that HMOs not able to meet such conditions and not having complete data to support their ACR submissions be placed under a corrective action plan as a condition for contract renewal.

We also recommend that the Secretary direct the Administrator to

- establish policies and procedures to periodically conduct on-site reviews of HMOs to verify for accuracy and reasonableness the data supporting their ACRs against their records and accounting system reports and
- revise HCFA regulations and incorporate provisions in HMO contracts to require that HMOs (1) certify the accuracy and reasonableness of their ACR submissions and (2) explicitly authorize HCFA to recoup from an HMO any excess payments that can be shown to have resulted from the HMO's use of data that were not accurate, current, or complete.

Agency Comments

Although HHS agreed with our recommendations, it reiterated its position that the ACR process is unnecessary because of the competitive forces of the marketplace. HHS noted that most HMOs offer Medicare beneficiaries additional benefits and 60 percent of the HMOs have elected to charge beneficiaries less than what they could have charged based on the HMOs' ACRs. Our report recognizes that there are competitive pressures on HMOs. However, it has not been demonstrated that competition is sufficient to make the ACR process unnecessary. Consequently, for reasons discussed on pages 57-58, we continue to believe the requirement for ACRs remains necessary, given HCFA's role in assuring the reasonableness of provider reimbursements and the acknowledged limitations in the AAPCC method of reimbursing HMOs.

With regard to our recommendations, HHS indicated the specific corrective actions it has undertaken or plans to undertake. Specifically, HHS told us that it

- plans to review its authority to require the standardization of ACR submissions. Also, starting with the 1989 contract period, HHS will require each HMO to consistently report the same categories and definitions of services. Furthermore, HHS has adopted specific plans aimed at improving its efficiency to better accommodate severe year-end review requirements.
- has revised its instructions to HMOs to (1) emphasize the need for using both volume and intensity adjustment factors in preparing ACRs and (2) require them to submit adequate supporting documentation.
- will establish written guidelines detailing when HMOs must use their own cost and utilization experience and explore when and how it will take corrective action in instances of noncompliance.
- will incorporate on-site monitoring of ACR development into its current monitoring program.
- will explore with its General Counsel whether our recommendation to require certification of the ACR needs statutory or regulatory changes before it can be implemented. HHS also is reviewing the possibilities of recouping excess payments caused by inaccurate or incomplete ACR data.

We revised the draft report in a number of places to incorporate other pertinent HHS comments. HHS's comments are included in appendix II.

Use of an Inappropriate Volume Adjustment by HMO A Overstates 1986 ACR Estimate in Five Service Categories

In chapter 2, we discussed the impact of HMO A not using its own data and using an inappropriate method to compute its intensity adjustment factors in its 1986 ACR. We also identified another problem, involving computation of volume factors, which resulted in the 1986 ACR revenue forecast being overstated by about \$1.9 million. These deviations from HCFA's HMO manual resulted in the revenue forecast in five service categories in the 1986 ACR being overstated by about \$6.1 million, we estimate.

HMO A did not use its most current data for calculating volume adjustment factors for five of seven ACR categories in its 1986 ACR. At the time the ACR was prepared, HMO A had utilization data for Medicare and non-Medicare members for the period July 1984 through June 1985. These data were not used to calculate the volume adjustment for the five categories. Instead, HMO A used older (calendar year 1984) data. For two ACR categories, we were unable to determine what the volume utilization factor should have been because utilization data were unreliable.

Also, HMO A did not properly use its calendar year 1984 data to reflect the utilization rate for its non-Medicare members' use of inpatient hospital service. The historical data showed a utilization rate of 263 days per thousand members. HMO A used 245 days, which incorporated a "productivity savings" to achieve a reduced overall inpatient hospital rate. The savings represented a management objective and were based on improper utilization data.

HMO A properly adjusted the inpatient hospital volume utilization rate for Medicare members in its 1986 ACR, to reflect the impact of enrolling new Medicare members in the risk contract program. But the HMO did not adjust other ACR categories. Medicare enrollment under the risk contract program had been closed for about 5 years, during which time Medicare members aged and the annual inpatient hospital volume utilization rate increased. In July 1985, the HMO was permitted to open its risk contract program to new members. The utilization rate, based on July 1984 through June 1985, decreased by an estimated 20.88 percent. HCFA accepted this decrease. However, we found that the volume utilization factor for outpatient hospital service, physician home visits, and radiologist visits did not incorporate an adjustment that reflected decreased utilization due to enrolling new Medicare members into the program. Further, the adjustment made for the ambulance and out-of-plan service categories reflected a 19.7 percent decrease, although the decrease was based on the same data used to compute the 20.88 percent reduction for the inpatient hospital category. In addition, the skilled

Appendix I
Use of an Inappropriate Volume Adjustment
by HMO A Overstates 1986 ACR Estimate in
Five Service Categories

nursing category was adjusted down only 5.92 percent, with no explanation as to why the adjustment was not larger.

The impact of these inaccuracies and omissions caused HMO A's volume adjustment factor for the five service categories to be greater than it should have been. This resulted in an overstatement of the ACR revenue forecast of about \$1.9 million, we estimate.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 7 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, "Medicare: Reasonableness of Health Maintenance Organization Payments Not Ensured." 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,

A handwritten signature in dark ink, appearing to read "R. Kusserow".

Richard P. Kusserow
Inspector General

Enclosure

Appendix II
Comments From the Department of Health
and Human Services

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Reasonableness of Health Maintenance Organization
Payments Not Ensured"

Overview

According to GAO, the Health Care Financing Administration's (HCFA's) process for reviewing, validating and approving the adjusted community rate (ACR) submissions provided little assurance that the ACR process is meeting its payment safeguard objective. GAO believes the process is susceptible to health maintenance organization (HMO) manipulation and error because HCFA does not always enforce its requirements that an HMO: use its own historic cost and utilization data as a basis for calculating its ACR; follow the prescribed computational methods to account for differences between Medicare and commercial members' volume and cost of services; and document the calculations. In addition, GAO believes that HCFA has not developed an effective monitoring program which could identify past and help avoid future problems. Finally, GAO reports that HCFA lacks specific authority to recover funds it has paid erroneously to HMOs because of inaccurate ACRs.

Generally, we agree with the recommendations that GAO has made to the Secretary. In fact, many of these recommendations have already been incorporated into the manner in which HCFA administers the ACR aspects of the Private Health Plan Option (PHPO) program. Other recommendations will take more time to study and refine, but we believe that they can and should be effectively implemented. It should be noted, however, that the report is based on the incorrect assumption that the ACR is an appropriate and necessary mechanism for assuring the reasonableness of risk payments. Moreover, several of the case studies and analyses cited by GAO are similarly based on incorrect assumptions. We would like to take this opportunity to set the record straight.

THE ACR IS THE PROBLEM

GAO indicates that it has uncovered problems in the ACR process, both in the actual ACR documents and in the manner by which HCFA processes the ACR proposals. We believe, however, that the GAO report addresses the symptoms of the problem, not the problem itself. All of the major items addressed in the report, such as the inadequacy of meeting the ACR potential, the difficulty in monitoring the ACR, the potential manipulation of the ACR, and the inadequate time available for ACR review, are really just symptoms of a problem. The problem is the ACR. We have continually and consistently espoused the view that the ACR is unnecessary to prevent excessive premiums paid by Medicare beneficiaries and that it is the competitive forces of the marketplace that result in the rich benefit packages that have been offered to Medicare beneficiaries as an alternative to traditional Medicare. An examination of the benefit packages shows the following information.

Appendix II
Comments From the Department of Health
and Human Services

Page 2

% of Plans
Offering the
Service

Additional Services Covered

94%	provide unlimited hospital days
87%	provide routine physicals
71%	provide eye examinations
67%	provide ear examinations
28%	provide outpatient drugs

We believe that this conclusion is supported by the fact that over 60 percent of plans which had premiums approved in their 1988 ACRs decided to waive at least \$1. Therefore, the Department has sought legislative authority to eliminate the ACR. The problems with the ACR itself are multiple:

- It is based upon estimates of what the plan expects to charge for the upcoming year.
- The HMO does not always have sufficient experience or data to develop its own utilization factors.
- The 45-day HCFA approval time frame does not allow sufficient time for advance verification by HCFA of the data in the package.

HCFA HAS TAKEN ACTION TO STRENGTHEN/STREAMLINE THE ACR PROCESS

HCFA has already taken a number of actions to strengthen and streamline the ACR process. Although we would like to see the ACR eliminated, we are, nevertheless, aware that it is still a requirement that must be met. To expedite the processing of adjusted average per capita cost (AAPCC) data by the plans, we have made the AAPCCs available, this year on magnetic tape or diskettes. In addition, for the first time, we have incorporated the ACR process into a software program capable of operation on a personal computer. The response from the plans has been good. We expect that the software program will expedite the plans' preparation of the ACR as well as its subsequent review by HCFA. In order to better manage the workload, we have also been conducting different types of reviews of the ACRs, based upon specific factors established for determining the depth of review. The ACR may receive a limited, full, or modified review. HCFA also developed an ACR data base, now in its second year, to assist us in determining the reasonableness of selected ACR data submitted by the plans.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to revise its instructions to HMOs on preparing ACR submissions to:

- require the use of a standardized ACR submission;

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Comments From the Department of Health
and Human Services**

Page 3

Department Comment

We agree that, ideally, the ACRs submitted by health plans should be standardized as much as possible so that comparisons can be made between contract periods and between HMOs. In reality, however, this is not always possible because the management information systems used by each plan vary to some degree and cannot readily be changed to accommodate the ACR process. Each system for collecting operating data is geared toward that plan's operations. This year, we are requiring each plan to consistently report, from year to year, the same categories and definitions of services. This will facilitate meaningful comparisons of a particular plan's data from one year to another. We also plan to review our legal authority to ascertain if the standardization can become a part of the ACR guidelines.

As stated above, we have also developed an automated ACR package. On August 2, 1988, a memorandum was sent to the plans announcing the availability of an automated version of the ACR calculation format. This will expedite the preparation of the ACR and facilitate HCFA's comparison and analyses of HMOs' data. We anticipate that a majority of the plans will use this computer disk in preparing their ACRs for 1989.

GAO Recommendation

- require HMOs to use both volume and intensity adjustments to calculate utilization factors and adequately document the basis for the factors used; and

Department Comment

We agree with the recommendation and have reinforced HCFA's position with the issuance to the plans of a revision to section 5300 of the Medicare HMO/CMP Manual (HCFA Pub. 75). The transmittal notice was sent on September 30, 1988 and emphasized the need for using both volume and complexity factors in preparing the ACRs. The notice also points out that documentation must be provided showing the source of the figures used and how they were computed for each Medicare service category even when the factor is one. Supporting data on all ACR entries must be provided for the ACR to be accepted.

GAO Recommendation

- stipulate the conditions under which HMOs will be permitted to use cost and utilization data other than their own for computing ACRs and establish a requirement that HMOs not able to meet such conditions and not having complete data to support their ACR submissions be placed under a corrective action plan as a condition for contract renewal.

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Comments From the Department of Health
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Page 4

Department Comment

We agree with the recommendation and will work toward establishing written guidelines detailing those instances in which renewing plans must use their own cost and utilization statistics in preparing ACRs. In the past, the number of Medicare enrollees belonging to a plan guided HCFA during its review of the ACR: low Medicare enrollment usually indicated that a plan had insufficient data to prepare an accurate ACR. As for those plans refusing to abide by these guidelines, we are exploring what would have to be done to establish the criteria for a corrective action plan and to consider the criteria during contract renewal.

GAO Recommendation

That the Secretary direct the Administrator to:

- establish policies and procedures to periodically conduct on-site reviews of HMOs to verify for accuracy and reasonableness the data supporting their ACRs against their records and accounting system reports; and

Department Comment

We agree with the recommendation and recognize the need for thorough on-site reviews of HMOs. To this end, HCFA intends to incorporate on-site monitoring of premium development into its existing HMO on-site monitoring program.

GAO Recommendation

- revise HCFA regulations and incorporate provisions in HMO contracts to require that HMOs (1) certify the accuracy and reasonableness of their ACR submissions and (2) explicitly authorize HCFA to recoup from an HMO any excess payments that can be shown to have resulted from the HMOs use of data that were not accurate, current, or complete.

Department Comment

We agree with the recommendation and have already submitted a memorandum to the Office of the General Counsel (OGC) inquiring as to whether the certification requirement can be added to the ACR guidelines, or needs a statutory or regulatory change before it can be implemented. As for the recoupment of excess HMO payments caused through the use of inaccurate or incomplete data by the plans, HCFA is currently reviewing this recommendation.

Other Matters

EXECUTIVE SUMMARY - Page 4

GAO

"The ACR process is not meeting its potential as a payment safeguard, judging from a review of ACRs submitted by 19 HMOs from 1985 through 1987. In 13 of the 19 HMOs, the ACR estimates were based, in part, on cost and utilization data other than the HMOs', even though HCFA's procedures generally do not permit the use of other data."

Now on p. 3.

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Comments From the Department of Health
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HCFA RESPONSE

It is difficult to respond to the assertion because the GAO draft report does not indicate whether the 13 HMOs were first-year plans. We need to know this in order to determine if they were justified in using cost and utilization data other than their own in preparing their ACRs. Current regulations do allow health plans contracting for the first time with HCFA to use data other than their own. The use of published data derived from studies and reviews conducted by private organizations is not automatically accepted by HCFA's auditors. The auditor will review the submitted published data for a first-year plan to ascertain if it is reasonable and in line with the operations of the plan. The source of the data, as well as its age, will be evaluated by the auditor in assessing its reliability. A list of published studies that have been approved by HCFA, and judged acceptable to establish volume and complexity factors, is supplied to plans upon request. (A list of these studies is also supplied to plans attending ACR seminars conducted by HCFA throughout the year.)

Furthermore, HCFA has approved the use of published data by second- and third-year plans in those cases in which it was judged to be more reliable than the plan's own data when preparing the ACR. This usually occurs when it is determined that low Medicare enrollment by a plan would not provide an adequate data base for the formulation of the ACR. In order for HCFA to reach this conclusion, however, the renewing plan should discuss with its HCFA auditor any deviation from the use of actual data prior to the submittal of the ACR. It is also required that the plan submit actual data for review even though published data was used in the ACR computations.

EXECUTIVE SUMMARY - Page 5

GAO

"Periodic on-site reviews of HMOs to verify the support for approved ACR submissions would establish a baseline for reviewing and comparing future submissions. However, during the 3 years ended December 1987, HCFA made monitoring visits to only 29 percent of the 154 risk contract HMOs. Usually, these visits lasted 1 day and consisted primarily of discussions with HMO officials and reviews of policies and procedures."

HCFA RESPONSE

Because of limited travel funds and workload consideration, HCFA has been unable to conduct ACR on-site reviews in sufficient quantity and depth to satisfy the concerns raised in the draft report. HCFA is currently re-examining this policy to determine its usefulness under the present circumstances, and what changes are needed to make the on-site reviews an even more reliable tool for gauging the accuracy of the ACR submissions. We would like to point out that when we did conduct an on-site review, a standard protocol was used to obtain information from the plan. In trying to conserve scarce travel funds, quite often several plans in the same area of the country were visited on the same trip.

Now on p. 4.

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Now on p. 4.

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EXECUTIVE SUMMARY - Page 5

GAO

"Specifying a common format could enhance HCFA's ability to review and compare ACR submissions from year to year and from HMO to HMO, providing HCFA a way to gauge the reasonableness of the HMOs' estimates. Presently, HCFA's instructions are not specific in delineating the format of HMOs' ACR submissions--i.e., the categories of services that must be separately identified and the services included in each category. As a result, ACRs have not been consistent in these areas."

HCFA RESPONSE

As stated earlier in our comments, we agree that a common format for submitting ACRs is desirable from an analysis standpoint; however, it is not always practicable to expect each plan to submit its categories of services in a format based on rigid guidelines. HCFA is requiring plans to prepare their ACRs in a similar format from year to year. Each plan's service categories should be consistent each contract period and be available for comparison purposes so that unexpected changes can be noted and reviewed further. We performed our own review of those ACRs included in GAO's study and found that there were 27 instances (comparison of one contract year to another) in which changes in service categories could have taken place. In 16 cases (59%), changes in service categories were made by plans from one ACR year to the next. However, after reviewing the contents of the individual plan folders for contract years 1985, 1986, and 1987 (when appropriate), we are of the opinion that seldom were the changes extensive and that meaningful comparisons could still be made.

We understand the concern GAO has in this area and will work toward making this comparison process possible. To this end, we have created an automated version of the ACR calculation format which will hasten the preparation of the ACRs by the plans and make it possible for HCFA to complete its review and analysis work in a timely manner.

EXECUTIVE SUMMARY - Page 5

GAO

"HMOs are not required to certify the accuracy of the data underlying their ACR submissions."

HCFA RESPONSE

As stated earlier in our comments, we agree that a certification of the ACR data by a health plan officer could add credence to the accuracy and reliability of the information provided by the plan. We have submitted a memorandum to OGC asking whether the certification requirement can be added to the ACR guidelines, or whether a statutory or regulatory change is needed before this step can be implemented. We will work with OGC closely in order to implement this recommendation prior to the next ACR season.

Now on p. 5.

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Now on p. 18.

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CHAPTER 2, Page 24

GAO

A benefit stabilization fund is maintained by HCFA in a noninterest bearing Treasury account available for use by an HMO for up to 6 years.

HCFA RESPONSE

A correction is needed. Once a benefit stabilization fund is established, the monies in it are available for use by the HMO for up to 4 years after the date of the establishment of the fund. After this date, any monies in the fund revert to the appropriate Medicare Trust Fund, as determined by HCFA.

Now on p. 21.

CHAPTER 2, Page 28

GAO

In its case study of HMO A, GAO reported that several factors resulted in the total Medicare premium to this HMO being overstated by about \$6.1 million, or 15 percent of the estimated revenue requirements for 5 ACR service categories.

HCFA RESPONSE

HCFA reviewed the plan's file folder and did not find sufficient information to agree or disagree with GAO's contention that a overstatement of \$6.1 million had occurred. Also, HCFA does not have the GAO audit workpapers that would substantiate the dollar finding. We plan to contact GAO to review its computations and hold discussions with the GAO auditors. Also, we plan to contact HMO A in an attempt to establish all the facts. It should be noted, however, that the plan waived a significant amount of the premium it could have charged.

Now on p. 24.

CHAPTER 2, Page 32

GAO

In its case study of HMO B, GAO objected to :

- 1) the plan using published data in preparing ACRs for 1985, 1986, and 1987 when it had a system of collecting utilization data needed to compute volume and intensity adjustments, and
- 2) the plan changing, between 1985 and 1986, the source of its published data used to compute volume and intensity adjustments in four of five ACR categories.

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HCFA RESPONSE

A review of the plan's 1985 and 1986 ACR folders revealed that the change in published data was justified. The study used in preparing the 1986 ACR was more current than the study used to compute the 1985 ACR. It was based on June 1984 data as opposed to the 1982 data used in preparing the 1985 ACR. Also, the study used in the 1986 ACR included volume and intensity factors whereas the 1985 ACR was based on 1982 data which only had a volume factor. HCFA encourages the plans to use the most current and appropriate studies available in preparing their ACRs.

As for this plan using published data as opposed to its own, HCFA accepted the plan's acknowledgment that continued problems with its automated claims processing system prevented it from generating accurate data in preparing its ACR submissions. GAO found this to be correct when it requested 1984 operating data from the plan when it conducted its on-site review. In the absence of a corrective action policy, the plan was allowed to use and update studies in preparing their ACR submissions for 1985, 1986, and 1987.

CHAPTER 2, Page 37

GAO

HCFA did not always enforce its requirements regarding the use of HMO-specific data. Also, some HMOs changed from using one published source of data to another from one year to the next without justifying and documenting the rationale as required by HCFA instructions.

HCFA RESPONSE

We agree that the use of published data by plans should be approved by HCFA in advance of receipt of the ACR and be documented and justified in the ACR folder. However, because of the tight time restraints under which HCFA was required to work, it was difficult to enforce every ACR requirement and yet process and approve each ACR within the 45-day time limit. As stated in the GAO report on page 47, "Given the short time period HCFA staff had to review and complete the ACRs, it would be difficult to do much more than what they were doing."

Now on p. 28.

Now on p. 35.

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