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Fact Sheet for the Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce

November 1985

MEDICAID REQUIREMENTS

Health Insuring Organizations

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-221166

November 27, 1985

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

In response to your November 19, 1985, request, we have reviewed the regulations and guidelines applicable to state Medicaid contracts with health insuring organizations (HIOs). An HIO is an entity that (1) pays for medical services provided to recipients in exchange for a premium or subscription charge paid by the state Medicaid agency and (2) assumes an underwriting risk.

HIOs are paid a negotiated, fixed amount per beneficiary per month to underwrite the cost of providing Medicaid benefits. HIOs then negotiate contracts with community providers--including health maintenance organizations, doctors, hospitals, and others--to actually provide Medicaid services. They are specifically prohibited from directly providing services. If the cost of providing Medicaid benefits exceeds the fixed monthly payment, the HIO suffers a loss, commensurate with the extent of its underwriting risk.

At your request, we focused our efforts on determining whether the Department of Health and Human Services (HHS) or its Health Care Financing Administration (HCFA), which administers the Medicaid program, have promulgated regulations or written guidelines, other than 42 C.F.R. 434.14, that specify

--the method a state Medicaid agency must use for procuring an HIO contract, the minimum qualifications that an HIO must possess, and the disclosure requirements to which HIOs are subject;

--the financial and utilization reporting requirements to which HIOs are subject;

--methods that HIOs must employ to ensure that Medicaid beneficiaries have access to quality care; and

--the amount of payments that an HIO may retain for its own financial benefit.

In summary, our review showed that HHS has not published regulations other than 42 C.F.R. 434.14 specifically governing contracts with HIOs. Further, because HIOs do not directly provide Medicaid services, detailed regulations governing other risk-based contracts do not apply to contracts with HIOs. HCFA officials told us, however, that other regulations and guidelines governing Medicaid programs establish general requirements applicable to HIOs. For example, contracts with HIOs must be awarded in accordance with federal procurement standards governing procurement methods and qualifications that bidders must possess.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this fact sheet until 30 days from its issue date. At that time we will send copies to HHS and other interested parties and make copies available to others on request.

Should you need additional information on the specifics of this matter, please call Jim Linz of my staff on 426-5246.

Sincerely yours,

Michael Zimmerman
Associate Director

MEDICAID REQUIREMENTS FOR

HEALTH INSURING ORGANIZATIONS

Under Department of Health and Human Services (HHS) regulations (42 C.F.R. 434.2), a health insuring organization (HIO) is defined as an entity that (1) pays for medical services provided to recipients in exchange for a premium or subscription charge paid by the state Medicaid agency and (2) assumes an underwriting risk. HIOs are paid a negotiated, fixed amount per beneficiary per month to underwrite the cost of providing Medicaid benefits. If the cost of providing the benefits exceeds the fixed monthly payment, the HIO suffers a loss, commensurate with the extent of its underwriting risk. An HIO differs from a health maintenance organization (HMO) in that it pays for services whereas an HMO provides services. According to the Health Care Financing Administration's (HCFA's) State Medicaid Manual (Part 2, Section 2102(F)), an HIO typically arranges through contracts with community providers--including HMOs, doctors, hospitals, and others--to provide Medicaid services in a given area for groups of recipients. However, the manual notes that because an HIO is not a provider of services, it may not generally make arrangements on an individual recipient basis. Nor, according to the manual, may it assume a medical responsibility for services.

State contracts with HIOs are governed by HHS regulations in 42 C.F.R. 434.14. In addition the State Medicaid Manual states that the usual Medicaid contracting rules (e.g., including competitive bidding) apply to HIO contracts. The manual also states that under an HIO contract, beneficiaries are given the same freedom-of-choice options they would have if the state were paying expenses directly. A waiver of these requirements can be granted under section 1915(b) of the Social Security Act.

The following questions and answers address the information the Chairman asked us to obtain concerning the regulation of HIOs.

1. Question:

Other than the regulation found at 42 C.F.R. 434.14, has HCFA issued any regulations or guidelines applicable to state Medicaid agency contracts with HIOs, especially those under which the HIO arranges for the provision of services to Medicaid eligibles?

Answer:

HHS has not issued any additional regulations specifically governing contracts with HIOs. However, the HIO regulations at 42 C.F.R. 434.14 specifically require that HIO contracts meet the general requirements for Medicaid contracts and subcontracts (42 C.F.R. 434.6). These regulations, in turn, require that all Medicaid contracts include provisions that define a sound and complete procurement contract, as required by 45 C.F.R. Part 74, Appendix G. Generally, Medicaid beneficiaries must be given a free choice among providers qualified and willing to perform Medicaid services. When establishing an HIO, states may need to obtain a waiver of this requirement under authority of section 1915(a) of the Social Security Act in order to restrict beneficiaries' freedom of choice in selecting providers. According to HCFA, HIOs operating under freedom-of-choice waivers must meet detailed federal requirements for those waivers.

HCFA has published guidelines covering contracts between state agencies and HIOs in the State Medicaid Manual (Part 2, Section 2080). These guidelines also cover contracts between state agencies and fiscal agents, health care project grant centers, private nonmedical institutions, HMOs, prepaid health plans, and contracts for automatic data processing equipment and services.

2. Question:

Do these regulations or guidelines:

(a) Specify the minimum qualifications that an entity must have in order to contract as an HIO?

Answer:

HHS regulations and guidelines do not specify minimum qualifications for an HIO. However, federal regulations governing the administration of HHS grants establish standards and guidelines for the procurement of supplies, equipment, construction, and services for federal assistance programs, such as Medicaid (45 C.F.R. Part 74, Appendix G). These regulations apply to contracts with HIOs. The guidelines were developed by the Office of Management and Budget (in Circular A-102) to provide uniform administrative requirements for grants-in-aid to state and local governments. Generally, the regulations require, among other things, that procuring agencies thoroughly assess bidders' capabilities by clearly defining the required goods and services to be procured and developing definitive evaluation standards.

(b) Specify the method for procurement of an HIO contract?

Answer:

While HHS regulations do not specify the method for procurement, they require that the contract and any subcontract be awarded in accordance with 45 C.F.R. Part 74, Appendix G. In general, these regulations require free and open competitive contract procurement. As the federal grantor agency, HCFA is authorized to permit a state to award a noncompetitively negotiated contract.

(c) Specify the disclosure requirements to which HIOs are subject?

Answer:

HHS regulations establish requirements regarding disclosure of ownership information (42 C.F.R. 455.100-106). Under the regulations, a "disclosing entity" is defined as a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent (a contractor that processes or pays vendor claims on behalf of a Medicaid agency). Because HIOs arrange for, but do not provide, services, they are neither providers nor fiscal agents. As a result, they are not disclosing entities within the meaning of the regulations and are not required to disclose the ownership information in accordance with the regulations.

(d) Specify the amount of Medicaid payments that an HIO may retain for its own financial benefit?

Answer:

Under HHS regulations (42 C.F.R. 434.14), contracts with HIOs must specify whether the HIO returns to the agency part of any savings remaining after allowable costs are deducted from the payments and, if savings are returned, the apportionment between the agency and the HIO. According to a HCFA official, no written guidance has been issued limiting the amount of savings an HIO may retain for its own financial benefit. However, payments to an HIO are subject to upper payment limits under 42 C.F.R. 447.361 and 447.362, depending on the type of contract. Payments to HIOs must be based on sound actuarial analyses and may not exceed in aggregate what a traditional Medicaid program would cost.

(e) Specify the quality assurance methods, including grievance procedures, that the HIO must, at minimum, employ?

Answer:

No specific regulations or guidelines have been issued specifying the quality assurance methods HIOs must employ. HCFA officials pointed out, however, that the state remains responsible under an HIO contract for ensuring that Medicaid beneficiaries receive quality care. Further, HCFA officials noted that in many places where HIOs have been established, states have had to obtain a waiver of section 1902(a)(23) of the Social Security Act in order to restrict Medicaid beneficiaries' freedom of choice in selecting a Medicaid provider. HHS regulations preclude states from obtaining such waivers restricting freedom of choice in selecting a provider if it results in a reduction in the quality of services provided (48 F.R. 23212, May 24, 1983).

(f) Specify the financial reporting requirements to which HIOs are subject with regard to their own operations?

Answer:

Neither HHS regulations nor HCFA guidelines establish financial reporting requirements specifically for HIOs. However, according to HCFA officials, state Medicaid agencies are responsible for monitoring HIOs' financial performance and are expected to establish reporting requirements.

(g) Specify the standards that an HIO must meet to assure access by program beneficiaries to services to which they are entitled under the state Medicaid plan?

Answer:

Neither HHS regulations nor HCFA guidelines establish separate standards an HIO must meet in order to assure Medicaid beneficiaries access to services. However, according to HCFA officials, the state Medicaid agency retains responsibility under an HIO contract for assuring that Medicaid beneficiaries have access to services and is expected to establish such standards.

(h) Specify the frequency and content of the utilization reports that the HIO must submit to the state agency regarding the use of services by beneficiaries?

Answer:

Neither HHS regulations nor HCFA guidelines establish separate utilization reporting requirements for HIOs. According to HCFA officials, the state Medicaid agency retains

responsibility for assuring that adequate data on beneficiary utilization of services are obtained to enable the state to monitor program operations.

(i) Specify the frequency and content of the financial reports that the HIO must submit to the state agency regarding the cost of the services for which it has arranged?

Answer:

Neither HHS regulations nor HCFA guidelines contain specific requirements for the submission of such reports to the state agency. According to HCFA officials, the state remains responsible for monitoring the performance of HIOs and is required by other Medicaid regulations and guidelines to establish reporting requirements.

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