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STATEMENT OF

MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

SELECT COMMITTEE ON AGING

UNITED STATES HOUSE OF REPRESENTATIVES

ON THE

SOUTH FLORIDA HMO DEMONSTRATION PROJECTS

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the results to date of our ongoing review of Medicare's health maintenance organization (HMO) demonstration projects in Florida. My statement will focus on the coordination problems that we identified between Medicare and the HMOs which result in duplicate or other erroneous payments to the HMOs, hospitals, physicians, or beneficiaries. We found that delayed recording of beneficiary enrollment dates and other coordination problems between Medicare and the HMOs led to

--Medicare paying non-HMO providers for services that HMOs had already been paid for,

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--doctors not being paid or being paid more than once for services provided,

--HMOs not paying beneficiaries' Medicare deductible and coinsurance charges for authorized services as called for under the Florida HMO agreements, and

--beneficiaries paying for services that the HMO should have paid for.

I will also discuss problems we identified with the enrollment and disenrollment procedures which can result in some beneficiaries being liable for substantial medical expenses.

We believe that the Department of Health and Human Services (HHS) needs to correct the systemic problems that lead to the situations outlined above. These problems include such things as carriers and intermediaries not knowing when beneficiaries are enrolled in an HMO and the breakdown in coordination among the carriers, intermediaries, HMOs, and the Health Care Financing Administration (HCFA). It is especially important to correct the problems now in view of the imminent nationwide expansion of the HMO program to serve Medicare beneficiaries and the potential adverse effects on beneficiaries and the provider community if other HMOs experience such problems. These matters are discussed in our interim report, Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48), which we issued on March 8, 1985.

The first part of my statement will discuss how the new HMO program operates, the number of HMO enrollees receiving services

outside the HMOs, and the need for better coordination between Medicare and the HMOs in determining who should pay for such services. Then I will discuss problems with enrollment and disenrollment procedures which can result in some beneficiaries being liable for substantial medical expenses.

BACKGROUND

In February 1985, HHS initiated a program to expand the use of HMOs by Medicare beneficiaries. This new program was preceded by 26 demonstration projects throughout the country to test HMOs' effectiveness. The four Florida projects we looked at involved about half of all Medicare beneficiaries enrolled in the 26 projects.

The demonstration projects and the HMOs that will participate in Medicare under the nationwide program differ from most previous HMO-type Medicare arrangements in two respects. First, the new program puts HMOs at risk because they are paid a fixed per patient fee or capitation payment to provide all covered services. The capitation payment is to be based on the average Medicare costs for all beneficiaries in each HMO's service area. Second, enrolled beneficiaries are required to obtain all their health care, except emergency or urgently needed services, from the HMO unless authorized by the HMO to obtain services elsewhere. This is known as the "lock-in" feature, and any services obtained by beneficiaries without the HMOs authorization are referred to as "out-of-plan." Neither the HMO nor Medicare is obligated to pay for unauthorized,

nonemergency services received from nonplan providers; the beneficiaries are personally liable.

NUMBER OF BENEFICIARIES RECEIVING OUT-OF-PLAN SERVICES

Of the 105,000 Medicare beneficiaries we compared with the payment files of the regular Medicare program, 6,737 (or 6.4 percent) had potentially[1] received some out-of-plan physicians' services while they were members of the four Florida HMOs. The total potential out-of-plan charges were about $2.6 million. In accordance with the lock-in provision, Medicare should deny (not pay) these claims. Based on all the denied claims, about half of the 6,737 beneficiaries had obtained out-of-plan services with charges of $100 or less, and about 9 percent had obtained such services with charges exceeding $1,000.[2]

Sixty-four people had obtained potential out-of-plan physician services for which they were charged from about $5,000 to about $17,000.[2] Our analysis of these beneficiaries' denied claims showed that the beneficiaries had paid about 14 percent of the claims. The HMOs paid about 53 percent of the claims because (1) the services had been authorized by them and the doctors had sent the claim to Medicare by mistake or (2) when the HMOs learned of the circumstances, they decided to pay the claims.

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[1]We use the term "potentially" because during our review of individual cases, we found that the Medicare carrier had received claims for services that had been authorized by the HMOs and should have been submitted to the HMOs.

[2]Some claims for out-of-plan services were submitted to carriers and denied more than once; therefore, these amounts overstate the unduplicated incurred charges.

For the remaining claims, either the doctors had not been paid or we did not determine the status.

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Of the $2.6 million in claims for out-of-plan physicians' services related to the four Florida HMOs, the regular Medicare program correctly denied $1.9 million and incorrectly allowed almost $750,000, or about 29 percent. The amounts paid represent "duplicate" payments because the costs of the services were included in the payment rates to the HMOs. GAO believes that the 29 percent error rate is too high.

In most cases about which we inquired, Florida Blue Shield--the carrier in Florida responsible for making payments to physicians--told us the incorrect payments occurred because of delays by HCFA in notifying the carrier that the beneficiary had enrolled in an HMO. According to the carrier, weeks or months passed before it was notified of enrollment dates. We verified that one cause of these delays was the lag time at HCFA in recording HMO beneficiary enrollment dates. The carrier paid any out-of-plan claim submitted in the interim because it was unaware of the beneficiary's HMO enrollment.

Also, our analysis of the claims for the 64 beneficiaries noted that a coordination problem between the HMOs and regular Medicare in handling denied claims. The Medicare carrier is

supposed to transfer such denied claims to the HMOs so that the HMOs can review and consider paying them if they were for authorized services or if the beneficiary had adhered to HMO requirements. However, at the four HMOs we could locate claims for only 60 percent of the billed charges for the 64 beneficiaries.

To the extent the remaining claims were not submitted to the HMO, it could not act on them. This could have resulted in beneficiaries or providers not being reimbursed for medical services authorized by the HMO but properly denied by the carrier. In some cases the HMO likely would have paid the claims because (1) the claims were related to hospital admissions that the HMOs had authorized, (2) the HMO had paid other related doctors' bills, or (3) the beneficiaries were not at fault. For example, one HMO paid $9,377 of $10,630 in claims originally denied by Florida Blue Shield for a beneficiary. The remaining $1,253 in claims were not sent to the HMO and, therefore, had not been paid at the time of our review.

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

Our analysis of the hospital bills applicable to the 64 enrollees with denied physician claims of over $5,000 indicated that HCFA's internal controls for coordinating the HMOs' hospital-related services with the regular Medicare program were highly vulnerable to error. In about one-fifth of the hospital admissions we reviewed, HCFA had not advised Blue Cross--the

principal intermediary in Florida for paying hospital bills--that the beneficiaries were enrolled in an HMO.

When HCFA does not give the intermediaries correct beneficiary enrollment information, various hospital-related payment errors occur because intermediaries use this information to determine who will pay for services provided--the HMO or Medicare. When a Medicare beneficiary is admitted to a hospital, the hospital notifies the intermediary, which in turn asks HCFA whether the beneficiary is eligible for service and is an HMO member. This information is passed on to the hospital. If the beneficiary is an HMO member and the hospital and HMO have a contractual agreement for providing services, the hospital bills the HMO directly. If the hospital has no agreement with the HMO, the intermediary will verify that the service is authorized (or an emergency) and will pay the hospital and tell HCFA to deduct the hospital payment from future capitation payments to the HMO. If the service is not authorized or is not an emergency or urgently needed service, the intermediary will deny the claim and notify the hospital, which in turn will bill the beneficiary.

One apparent cause of the incorrect enrollment information was the lag times between the effective dates of enrollment and the recording of those dates in HCFA's information system. For a 13-month period ended January 1985, the enrollment information was recorded from 16 to 37 days <u>after</u> the effective enrollment

dates. To the extent that HCFA received inquiries during these lag periods, it would have provided incorrect responses.

The incorrect enrollment information, along with other coordination problems between HCFA, the intermediaries, the HMOs, and hospitals, led to the following undesirable situations.

--Hospital bills were incorrectly paid, but the related bills for physicians' services were correctly denied, which could cause beneficiary confusion concerning the lock-in provision.

--The costs of hospital services authorized by the HMOs were not correctly charged to them, resulting in program overpayments.

--The costs of hospital services not authorized by the HMOs were charged to them, which resulted in underpayments to the HMOs or Medicare payments for noncovered services.

--HMOs did not pay beneficiaries' Medicare cost-sharing amounts as provided under the HMOs' benefit structure.

In view of the imminent expansion of the HMO program nationwide and the negative effects that payment errors can have on the Medicare program, HMOs, service providers, and beneficiaries, HCFA needs to correct these problems. Corrective action should center on overcoming (1) the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and (2) the

problems with the computerized exchange of data among carriers, intermediaries, HMOs, and HCFA.

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

In addition to the coordination problems involving the HMOs and the administrative structure for paying providers under the regular Medicare program, we identified two other problems associated with the lock-in provision and the enrollment and disenrollment procedures. The first problem relates to whether and when the HMOs or the regular Medicare program is responsible for the cost of services provided to beneficiaries who are hospitalized on the effective date of their enrollment. The second problem relates to beneficiaries who obtain out-of-plan services during the period when they have signed a disenrollment form but must continue to obtain services through the HMO until the effective date of disenrollment.

Uncertain status of beneficiaries in the hospital on the effective date of enrollment

Medicare's enrollment regulations and procedures do not clearly spell out the status of a beneficiary who is hospitalized after signing an enrollment form for an HMO and is in the hospital on the effective date of HMO membership. Under the demonstration projects, this period could range from 2 to 6 weeks. We identified at least seven cases in which a beneficiary was in this situation. In at least five of these cases, Blue Cross had paid the hospital bill because the

admission and HCFA's response to the inquiry about eligibility status were based on a date before the effective enrollment date. However, in all seven cases most of the related doctor bills for services provided on and after the enrollment date were denied by Blue Shield because its records showed that the beneficiary was enrolled in an HMO.

Further, because the HMOs did not authorize the hospital admission, their responsibility for these doctor bills was not clear. In four cases, the HMO had reviewed those claims it received and had paid all or part of them, but in two cases the HMO had not received any denied claims from Blue Shield and consequently had paid nothing.

Although the incidence of such cases was relatively small, the financial effect on beneficiaries and their families can be significant. For example, in one case a beneficiary was in the hospital on the effective date of his enrollment, and he or his wife had paid $5,747 in doctors bills denied by the carrier for services provided during the effective date of his HMO enrollment.

One solution to this problem would be to clearly spell out in the regulations that regular Medicare would be responsible for the portion of the medically necessary hospital and doctor bills up to the effective enrollment date, and the HMOs would be responsible for the portion of the bills incurred afterward even though it might not be practical to transfer the cases' medical management to the HMO. An alternative solution would be for Medicare to be made responsible for all costs until the patient

is discharged, and the HMO's monthly capitation payment could be proportionately reduced for the days involved.

Services obtained during the disenrollment waiting period

Of the 64 individuals with total denied physician claims over $5,000, at least 14 began to obtain out-of-plan services within a week of the date they signed the HMO disenrollment forms. The forms included a statement that all services, except "emergency" or "urgently needed" services, had to be provided or arranged by the HMO until the effective date of the disenrollment, which under the demonstrations should have been from 2 to 6 weeks later. Nevertheless, these beneficiaries incurred substantial out-of-plan medical bills for which they were liable during the waiting period. For example, one beneficiary entered a hospital 2 days after requesting disenrollment from the HMO and incurred $36,180 in claims during the disenrollment waiting period. Of this amount, $26,350 was owed by the beneficiary or was written off as uncollectable, and $9,830 was incorrectly paid by Medicare.

Under the Social Security Act, a member may terminate enrollment with an HMO no earlier than the first day of the second month following the month in which the HMO receives the request for the termination. We believe that regular Medicare coverage should be made available for beneficiaries who obtained necessary services during the waiting period between the date that they apply for disenrollment and the effective date.

In our opinion, beneficiaries who are dissatisfied with an HMO service and believe they need medical treatment should not have to wait several weeks or months to obtain it. On the other hand, if it is eventually shown through complaints and grievances that an HMO was remiss in not providing needed services that a beneficiary obtained out-of-plan shortly after disenrollment, the HMO should be required to accept the responsibility for such services. This would discourage HMOs from withholding treatment as a means of encouraging enrollees with costly health problems to disenroll.

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As indicated in my opening remarks, our testimony today covers our interim report. Our review of the four southern Florida HMO projects will address such issues as (1) the HMOs' marketing and enrollment methods; (2) actions being taken to assure quality care is provided; (3) HMOs' contracting arrangements with health care providers, such as hospitals and medical specialists; and (4) the reasonableness of Medicare HMO payment rates. We expect to issue our final report later this year.

This concludes my statement. We will be glad to answer any questions you might have.