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Issues Raised by Florida Health Maintenance Organization Demonstrations

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To the President of the Senate and the
Speaker of the House of Representatives

This report summarizes the results of our review of Medicare's health maintenance organization program, focusing on four such organizations in Florida. We discuss the adequacy of financial and quality of care safeguards for Medicare beneficiaries, the reasonableness of Medicare payments to health maintenance organizations, and the effectiveness of Department of Health and Human Services oversight.

Because of the rapid growth in this program, problems we identify in this report need to be resolved to help prevent similar difficulties from arising as more health maintenance organizations enter the program. The Department's oversight efforts have not been sufficient to assure that all Medicare requirements are being adhered to.

This review was done at the request of Congressman Lawrence J. Smith and other members of the Florida congressional delegation. We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; members of the Florida congressional delegation; congressional committees and subcommittees; and other interested parties.

Charles A. Bowsher
Comptroller General
of the United States

Executive Summary

Purpose

Operating under a new type of risk contract, health maintenance organizations (HMOs) are emerging as a major option by which Medicare beneficiaries can receive health services. Medicare pays an HMO with such a risk contract on a capitation basis (a fixed amount per Medicare enrollee for all covered services). According to its ability to provide covered services for less than the predetermined rate, the HMO makes or loses money on the contract.

During 1985, Medicare enrollment in risk-based HMOs grew by more than 73 percent, from 248,000 to 431,000, and is expected to nearly double in the next 2 years. Medicare paid about $415 million to these HMOs in fiscal year 1985; however, for the period October 1985 through June 1986, Medicare paid about $1.1 billion.

Because capitation payment creates strong financial incentives for efficiency, the administration is expected to propose other Medicare initiatives employing this approach. While capitation has significant potential for containing health care costs, it also poses the danger of diminished quality of care should an HMO try to cut costs excessively. Partly to allay the Congress' concerns about this and other matters and to test the capitation concept, the Department of Health and Human Services (HHS), which administers Medicare, initiated a national demonstration of risk-based HMOs.

This report assesses results of the demonstration by focusing on four south Florida HMOs and examining HHS mechanisms for monitoring HMO activities; federal standards for HMO financial solvency and enrollment; HMO marketing practices, costs, and grievance procedures; and Medicare savings from capitation. As of December 1985, the four HMOs studied—International Medical Centers, Inc., HealthAmerica, Comprehensive American Care, Inc., and AV-MED—had enrolled 155,857 Medicare beneficiaries, about 36 percent of those in Medicare risk HMOs nationwide.

The review was requested by Representative Lawrence J. Smith and other members of the Florida congressional delegation.

Background

Risk-based HMOs are expected to save Medicare 5 percent without reducing services. This was the purpose of a provision in the Tax Equity and Fiscal Responsibility Act of 1982 that authorized HHS to pay each such HMO 95 percent of Medicare's average costs (in that geographic area) to provide Medicare enrollees with all covered benefits.

These risk HMOs must meet certain federal requirements intended to protect beneficiaries. In addition to demonstrating financial solvency, the HMOs must enroll at least 5,000 members over whom to spread risk and generally accept no more than 50 percent Medicare and Medicaid beneficiaries (to forestall quality-of-care problems). Also, the HMOs must assure HHS that their marketing practices are not misleading and that they have adequate beneficiary grievance and internal quality assurance procedures.

Results in Brief

In network-type HMOs, the beneficiary protections concerning HMO financial solvency and enrollment were substantially limited. Such HMOs delivered many services through subcontractors (clinics, physician groups, etc.). Although the subcontractors assumed most of the HMO's financial risk, the legislative safeguards did not apply to them and they had received little federal or state oversight.

Medicare's payments to the HMOs were probably too high because the program did not adjust rates for enrollees' health status. Payments were based on average Medicare costs, but GAO found that HMO enrollees were healthier than the average beneficiary as measured by mortality rates. Thus, HMO enrollees generally would need less medical care and cost the HMOs less overall, and the HMO program is unlikely to achieve the intended Medicare saving.

Also, none of the four Florida HMOs was fully complying with federal requirements to inform Medicare enrollees of their rights to grieve and appeal denied claims or services. The low volume of appeals and the newness of the HMO system to Medicare beneficiaries suggest that such information is important.

Principal Findings

Federal Safeguards Limited in Effect

A network-type HMO organizational structure was operated by International Medical Centers, Inc., and being developed by Comprehensive American Care, Inc. Under such an arrangement, subcontractors assume much of the HMO's risk, but need not meet federal requirements concerning HMOs' financial solvency and enrollment. For example, of International Medical Centers' 103 subcontractors, only 3 enrolled more than 5,000 persons. Together, 103 subcontractors served 88,635 Medicare

enrollees. Further, of 48 subcontractors reviewed by International Medical Centers' auditors, the finances of 16 were found to need improvement and 5 refused to give financial data to the HMO's auditors.

Medicare Capitation Rates Excessive

To reduce Medicare outlays by 5 percent as envisioned when the law was enacted, the health status of HMO enrollees would have to be representative of the general Medicare population. An enrollment more or less healthy than average would make the per capita Medicare payment too high or too low. In 27 demonstration HMOs nationwide, GAO found the mortality rate to be only 77 percent of that projected. By this measure, Medicare enrollees were healthier than average, making capitation payments too high at this time. To achieve expected program savings, GAO's analysis indicates, Medicare would have to cut capitation rates by about 5 percent below present levels.

Notification of Grievance, Appeal Rights Inadequate

The four Florida HMOs had not given their Medicare enrollees written descriptions of HMO Medicare appeals procedures, although Medicare regulations require this. Such information helps assure that enrollees know how to seek redress for denied claims or services.

For the four Florida HMO's, from the time they began operating as demonstration projects in 1982 through 1984, only two Medicare appeals were filed by enrollees. In 1985, perhaps due to limited corrective measures by HHS, 10 appeals were filed from among the four HMOs. But more needs to be done to better inform enrollees of their rights.

Continued Close Federal Oversight Important

These problems and others covered in this report, including the absence of a federally sponsored peer review function, late payment by an HMO of provider billings, and the potential for HMOs to screen out less healthy applicants, warrant continued attention by HHS. Such problems need to be dealt with quickly to ensure they do not become widespread as the HMO program expands nationally.

Recommendations

HHS should issue regulations specifying standards for financial solvency and enrollment HMOs must require of subcontractors bearing substantial risk. This would help assure that existing beneficiary safeguards achieve intended results. Also, to improve notification to beneficiaries of their grievance and appeal rights, HHS should give HMOs explicit guidance on what constitutes acceptable notification.

To better assure that the HMO program reduces overall Medicare outlays as expected, HHS should reduce the current HMO payment level to more accurately account for the health status of HMO enrollees. GAO's analysis indicates that a 5-percent aggregate reduction in rates would be appropriate currently, given the variation in health status between HMO enrollees and the general Medicare population.

Comments

HHS and three of the four HMOs reviewed commented on this report (International Medical Centers, Inc., was asked to comment but elected not to). HHS agreed with GAO's recommendation to improve notification to beneficiaries of their grievance and appeal rights. HHS took no position on GAO's recommendation to issue regulations specifying standards for HMO subcontractors.

Both HHS and the HMOs disagreed with GAO's recommendation to reduce the current HMO payment level to more accurately account for HMO enrollees' health status. Generally, neither HHS nor the HMOs agreed with GAO that its analysis of 27 HMOs was sufficient to support the recommendation, and they questioned adjustments in estimations of HMO enrollee mortality rates and their effects on expected program savings. GAO believes its results demonstrate that there are sufficient differences between HMO enrollees and the general Medicare population not accounted for by the HMO payment mechanism to warrant a reduction in payment rates to account for these differences. Without such an adjustment, there is no assurance that the HMO program will produce the Medicare savings expected when the Congress enacted the HMO provisions.

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Abbreviations

AAPCC	adjusted average per capita cost
ACR	adjusted community rate
APR	average payment rate
AV-MED	AV-MED, Inc.
CAC	Comprehensive American Care, Inc.
CMP	competitive medical plan
ESRD	end-stage renal disease
GAO	General Accounting Office
GHPO	Group Health Plan Operations
GPPP	group practice prepayment plan
HCFA	Health Care Financing Administration
HCGPMST	HCFA Group Health Plan Master Record
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRS	Department of Health and Rehabilitative Services
IMC	International Medical Centers, Inc.
IPA	individual practice association
OHMO	Office of Health Maintenance Organizations
PHS	Public Health Service
PPS	prospective payment system
PRO	Peer review organization
PSROs	Professional Standards Review Organizations
SSA	Social Security Administration
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 risk contracts, HMOs agree to provide all the Medicare-covered services beneficiaries need for a fixed amount (or capitation rate) and incur a "profit"[1] or loss depending on their ability to provide covered services for less than the fixed payment. Until the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248), only one HMO had a risk contract on a continuing basis. TEFRA made a number of changes to the law regarding risk contracts that enhanced the attractiveness of such contracts to HMOs. As a result, the number of HMOs with risk contracts has expanded rapidly since the TEFRA implementing regulations became effective in February 1985.

From the HMO's perspective, the incentive to enter into a risk contract is that it can make the same profit on its Medicare patients as it earns in its private lines of business. Unlike risk-sharing contracts under prior law, this new program establishes payment rates prospectively, with no retrospective adjustment for costs incurred. To the extent that an HMO's Medicare profits are expected to exceed those made on their non-Medicare business, however, TEFRA requires the excess to be returned to the Medicare program through reduced HMO capitation payments or to beneficiaries through either reduced cost-sharing or broader benefits. Generally, HMOs have elected to return their excesses in the form of reduced cost sharing, including reduction or elimination of deductibles, copayments, and hospital day limits, or increased benefits. Increased benefits have included physician services not normally covered, such as routine physicals, vision and hearing exams, prescription drugs, and dental care.

This richer benefit package and the incentives to HMOs have resulted in rapid growth in both the number of risk-based HMOs and enrollment in them by Medicare beneficiaries. In fiscal year 1985, Medicare payments to HMOs under risk-based contracts totaled about $415 million; however, for the period October 1985, through June 1986, these payments increased to about $1.1 billion. Projections are for continued rapid growth.

[1]Throughout the report, we use "profit" to refer to amounts that HMOs may retain Many HMOs are nonprofit organizations and may use excess revenues only for the purposes for which they received their tax exemption For nonprofit HMOs, the term is technically "excess of revenues over expenses "

Prior to the effective date of TEFRA, Medicare entered into 26 HMO risk contracts on a demonstration basis to test risk-based HMO contracting.[2] Because of beneficiary inquiries and complaints, Representative Lawrence J. Smith asked us on January 30, 1984, to review four of the HMO demonstration projects operating in south Florida. Later, other members of the Florida congressional delegation also asked us to review these HMOs.

On March 8, 1985, we issued an interim report on the timeliness of processing by the Health Care Financing Administration (HCFA) of HMO enrollments and disenrollments for Medicare beneficiaries, HMO enrollees' understanding of the HMO "lock-in" provision,[3] and the extent of beneficiary liability for services provided outside the HMO.[4] This report, which completes our review of HMOs under this request, focuses on the following four issues:

- the oversight activities of federal and state HMO agencies,
- HMOs' contractual arrangements with their subcontractors,
- the reasonableness of Medicare HMO payment rates, and
- HMOs' grievance procedures and marketing practices.

Medicare and HMOs

The Medicare program, which began July 1, 1966, was authorized by the Social Security Amendments of 1965, which added title XVIII to the Social Security Act (42 U.S.C. 1395). Medicare pays for much of the health care costs for eligible persons age 65 or older and certain disabled people. The program is administered by HCFA, under the Department of Health and Human Services (HHS).

Medicare provides two forms of protection:

- Medicare part A, Hospital Insurance for the Aged and Disabled, covers services furnished by institutional providers, primarily hospitals, home health agencies, and, after a hospital stay, skilled nursing facilities. Inpatient care is subject to various deductible and coinsurance amounts. Part A is financed principally by taxes on earnings paid by employers,

[2]In addition to the 26 HMOs, in 1980 and 1981 HCFA entered into demonstration contracts with six other risk-type HMOs that subsequently entered into TEFRA risk-type contracts.

[3]This requires that, except for emergency or urgently needed services outside the HMO's service area, beneficiaries must obtain services exclusively through the HMO

[4]Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar 8, 1985)

employees, and self-employed persons. During calendar year 1985, about 30 million people were eligible for part A benefits, and benefit payments were about $47.6 billion.

- Medicare part B, Supplementary Medical Insurance for the Aged and Disabled, covers physician services, outpatient hospital care, and various other medical and health services. This insurance generally covers 80 percent of the reasonable charges for services, subject to an annual $75 deductible. Enrollment is voluntary. Part B is financed by beneficiaries' monthly premium payments and appropriations from general revenues. During calendar year 1985, about 29.9 million people were enrolled, and part B benefit payments were about $22.9 billion, of which about 22 percent was financed by enrollees' premiums, 73 percent by appropriations, and 5 percent from interest.

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

Only in the early 1970's did the term "health maintenance organization" come into widespread usage. Consequently, the original Medicare statute did not explicitly provide for reimbursing these organizations, but rather section 1833 included provisions for reimbursing, on a reasonable-charge or reasonable-cost basis, group practice prepayment plans (GPPPs) for part B services to Medicare eligibles enrolled in such plans. Until 1972, this was the only legislative authority for paying HMOs. In the following sections, we discuss the legislative history of HMO reimbursement.

HMO Reimbursement Before TEFRA

TEFRA's HMO provisions had their genesis in legislation initially proposed by the House Committee on Ways and Means in May 1970 and again in May 1971. Because the original Medicare statute reimbursed GPPPs on the basis of reasonable costs or charges, there was congressional concern that Medicare was not taking advantage of the financial incentives that HMOs might offer when paid on a prospective per capita basis. Paying HMOs prospectively gives them strong incentives to institute enrollee utilization controls and efficient management practices; their profitability depends on their ability to provide all enrollee services at less cost than the prospectively determined rates. Accordingly, the Committee recommended that the Medicare statute be amended to allow

Medicare to pay HMOs on the basis of prospectively determined fixed per capita rates. This provision was passed by the House of Representatives in June 1971.

The House version provided that HHS determine HMO rates annually at a rate actuarially equivalent to 95 percent of the estimated amount (adjusted for such factors as enrollees' age and morbidity differentials) that Medicare would pay on average for services to non-HMO enrollees. Through this mechanism, the Committee expected to save Medicare 5 percent over average payments made on behalf of beneficiaries not enrolled in HMOs.

To help guard against potentially excessive HMO profits, the House also proposed that HMOs' profits on their Medicare business be limited to no more than the profits on their non-Medicare business. An HMO would have had to submit to HHS a report at the end of each year's operation showing the HMO's profitability on Medicare (called the "rate of retention") and its profitability on non-Medicare business. To the extent that the former exceeded the latter, the HMO would have to refund the difference to Medicare or alternatively use the difference to pay for additional benefits or to reduce premiums charged to Medicare beneficiaries.

But this legislation was not adopted (although similar provisions ultimately were enacted in TEFRA as discussed below). Instead, the Congress adopted a revised HMO coverage provision in the Social Security Act Amendments of 1972 (Public Law 92-603), which added section 1876 to the Social Security Act. The Congress expressed concern that prospective payment might result in excessive cost-cutting by HMOs, reducing the quality of care to Medicare enrollees, and that it might be impossible to calculate an actuarially equivalent payment rate that would assure that the HMOs would not receive excessive profits.

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

". . . The first area of concern involves the quality of care which the HMO's will deliver Most existing large HMO's provide care which is generally accepted as being of professional quality. However, if the Government begins on a widespread basis, to pay a set sum in advance to an organization in return for the delivery of all necessary care to a group of people, there must be effective means of assuring that such organization will not be tempted to cut corners on the quality of its care (e g., by using marginal facilities or by not providing necessary care and services) in order to maximize its return or 'profit'. Under present reimbursement arrangements,

although there may be no incentive for efficiency, neither is there an incentive to profit through underservicing and other corner-cutting.

"The second problem area involves the reimbursement of HMO's. 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."

The new section 1876, in large part, retained Medicare's policies of basing HMO reimbursement on costs, although it gave HMOs the option to enter into cost-based or risk-based contracts. Under cost-based contracts, HMOs functioned similarly to GPPPs except that the payments could include the costs of both part A and part B covered services. As with GPPPs, Medicare members could use and receive reimbursement for out-of-plan services.

Under the 1972 amendments, risk-contracting HMOs also were paid on the basis of their costs to provide parts A and B services. However, an HMO's allowed costs per member were compared to 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, it had to absorb the loss or carry it over to be offset by future "savings." If the HMO's costs were less than its AAPCC, it shared the savings with Medicare on a 50-50 basis. The net effect of the profit-sharing formula was that the HMO's share of savings was limited to 10 percent of the AAPCC. Under risk-based contracts, Medicare enrollees were subject to a lock-in feature, which generally provided that except for "emergency and urgently needed services" all health care for enrolled beneficiaries must be provided by or authorized by the HMOs.

To minimize potential quality-of-care problems concerning risk-based HMOs, the 1972 amendments added several requirements that HMOs generally had to meet before entering into a Medicare contract. Specifically, HHS could contract on a risk basis only with

". . . substantial established HMO's (a) with reasonable standards for quality of care at least equal to standards prevailing in the HMO area and (b) which have sufficient operating history and enrollment to permit evaluation of the capacity to provide appropriate care and to establish capitation rates. Established HMO's would have (1) a minimum enrollment of 25,000 not more than half of whom are 65 or older and (2) have been in operation for at least 2 years . . "

The Secretary could exempt HMOs from the 25,000-enrollment requirement if they (1) enrolled at least 5,000 members and (2) operated in sparsely populated areas and had demonstrated, through at least 3 years of successful operation, the capacity to provide health care services of proper quality on a prepaid basis.

HMOs did not regard this risk-based option very favorably, apparently because their profits were limited and shared with Medicare and their losses had to be fully absorbed, and because of the 25,000-member enrollment requirement. Consequently, between 1972 and the enactment of TEFRA in 1982, only one HMO elected to contract with Medicare on a continuing basis under the risk-based option.

Provisions Liberalized Under TEFRA

TEFRA encouraged more risk-based HMO[5] contracts. Section 114 of TEFRA changed the Medicare law, amending section 1876 of the Social Security Act to (1) liberalize the beneficiary enrollment standards of the section and (2) adopt reimbursement provisions similar to those first proposed in 1971. The 25,000-enrollee standard was reduced to 5,000 enrollees, no more than 50 percent of whom could be Medicare and Medicaid enrollees. This allowed more HMOs to qualify for Medicare contracts than under section 1876.

Also, TEFRA created financial incentives for HMOs to participate in Medicare. Similar to the 1971 proposal for a "rate of retention," section 114 gave HMOs an opportunity to profit on Medicare as much as on their other lines of business. HMOs were allowed reimbursement on the basis of fixed per-patient payment rates of 95 percent of the AAPCC. But, instead of sharing savings with Medicare, HMOs could retain all profits up to the level of profits earned on their non-Medicare enrollment. Also

[5]TEFRA provisions also apply to competitive medical plans (CMPs), which are plans eligible to contract with HCFA for Medicare payment but do not meet the definition of HMOs in the Public Health Service Act. Our review did not include any CMPs. While there are several differences between CMPs and federally qualified HMOs, a principal distinction is that federally qualified 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.

similar to the 1971 proposals, the HMOs had to use any savings above this amount to give Medicare members additional health benefits or reduced cost sharing,[6] or alternatively to reduce the Medicare payment rates. The major distinction between the 1971 proposed retention factor and that under TEFRA was that TEFRA required profits to be calculated prospectively instead of retrospectively.

In enacting TEFRA, however, the Congress retained the concerns expressed in 1972—that the AAPCC methodology for computing HMO payment rates might not assure that the resulting rates were actuarially equivalent (equal to what Medicare would otherwise pay for a comparable group of Medicare non-HMO enrollees). Specifically, there was concern that under the AAPCC methodology the adjustments would not adequately reflect the relative health care needs of Medicare beneficiaries who enrolled in the HMOs as compared to beneficiaries in the regular Medicare fee-for-service system. Without adequate adjustments to Medicare average costs, payment rates would either be too high or too low depending 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 the 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.

In May 1984, HHS published the proposed regulations to implement section 114 of TEFRA. The final regulations were issued in January 1985 to be effective February 1, 1985. The Secretary provided the required notification to the congressional committees on January 7, 1985.

Public Health Service Act A so Applicable

In addition to TEFRA, HMOs are also governed by provisions of title XIII of the Public Health Service (PHS) Act of 1973. Provisions of this legislation are administered by the Office of Health Maintenance Organizations (OHMO) within HHS.[7]

[6]Under the four Florida demonstration projects discussed throughout this report, the beneficiaries are not liable for any deductibles or coinsurance amounts as they would be under the regular Medicare program Each HMO also provided additional health benefits

[7]During our review, OHMO was an agency of HHS' Public Health Service Effective March 14, 1986, OHMO responsibilities were transferred to HCFA.

To enter into a risk-based contract with Medicare, HMOs must first receive federal qualification from OHMO. To qualify, among other things, they must meet certain financial solvency requirements to protect enrollees against the risks of the HMO becoming bankrupt. Among these requirements are that the HMO have (1) assets greater than its "unsubordinated" liabilities; (2) sufficient cash flow and adequate liquidity to meet its obligations as they become due; and (3) a net operating surplus.

Also, in qualifying an HMO, OHMO reviews such factors as the HMO's management, market area, compliance with state requirements, quality assurance mechanisms, and the availability, accessability, and continuity of services (see p. 34).

Demonstration and TEFRA HMOs

To gain experience with HMO risk-based contracting for Medicare services, HCFA awarded contracts to 32 HMOs that became operational as demonstration projects between 1980 and 1984 and that subsequently converted to TEFRA contracts on either April 1 or July 1, 1985. These 32 HMOs included two groups—6 pre-TEFRA HMOs that began operations in 1980 or 1981 and 26 others that began operations between 1982 and 1984.

Two months after regulations implementing TEFRA became effective (Feb. 1, 1985), 27 of the 32 HMO demonstrations were converted to TEFRA risk contracts. In addition to the 32 HMO demonstrations, 100 other HMO (or CMP) TEFRA risk contracts were in effect as of May 1986. Consequently, as of May 30, 1986, there were 132 HMOs (or CMPs) with Medicare risk contracts operating in 31 states, with a total Medicare enrollment of 630,374. According to HCFA, as of May 30, 1986, an additional 55 TEFRA risk contract applications were pending.

This report deals principally with four HMO demonstration projects in the Miami, Florida, area that converted to TEFRA risk contracts in April 1985. The dates the demonstrations began and the number of Medicare beneficiaries and amounts of Medicare payments as of July 1, 1986, are shown in table 1.1.

Table 1.1: Four Florida HMO Demonstration Projects: Summary Data

Payments in thousands

HMO	Start of Demonstration project	No. of Medicare enrollees (July 1, 1986)	Medicare payments through July 1, 1986
International Medical Centers, Inc (IMC)	8/1/82	135,203	$781,257
AV-MED Inc (AV-MED)	11/1/82	6,811	65,650
Comprehensive American Care, Inc (CAC)	10/1/82	18,182	75,647
HealthAmerica[a]	2/1/83	2,986	17,378
Total		**163,182**	**$939,932[b]**

[a]Formerly Health Care of Broward

[b]Includes $121,180,000 withheld by HCFA to pay, on the HMOs' behalf, hospital bills for IMC, AV-MED, and HealthAmerica (See discussion on p 76)

Source HCFA

Objectives, Scope, and Methodology

In response to Representative Smith's request of January 30, 1984, and subsequent discussions with his office, as well as the concerns of other members of Florida's congressional delegation, we agreed that our review would address the following questions as they related to the four Florida demonstrations (the chapters in which they are covered are indicated):

1. What are the respective roles of HCFA and the state concerning the regulation of HMOs, particularly in the areas of financial responsibility and marketing? (chapter 2)

2. What role do peer review organizations (PROs) in the state have in assuring the quality of care provided under these demonstration projects? (chapter 2)

3. What arrangements have the HMOs made to provide beneficiaries with health services through either subcontracts or other arrangements with primary health care providers such as hospitals and medical specialists, and what are the effects on existing providers? (chapters 2 and 3)

4. How are the Medicare premium rates determined, and do they appear reasonable? (chapter 4)

5. For beneficiaries who disenroll from an HMO, what has been their subsequent claims experience under Medicare? (chapter 4)

6. If information already exists, how do Florida's HMOs compare with demonstrations in other parts of the nation? (chapters 4 and 5)

7. To what extent have Medicare beneficiary claims for service provided outside the HMO been denied, both while the beneficiary was enrolled and after disenrollment, and what are the procedures for assuring that beneficiaries can disenroll and still maintain Medicare coverage? (chapter 5)

8. What procedures must beneficiaries follow to obtain emergency services outside the HMO? (chapter 5)

9. If a Medicare beneficiary is dissatisfied with the service provided, what recourse does he or she have through grievance procedures involving either the HMO or HCFA? (chapter 6)

10. How much of the Medicare premiums do HMOs spend for marketing, advertising, and overhead as compared to direct patient care? (chapter 7)

To answer these questions, we reviewed HCFA and OHMO records and interviewed agency officials in Baltimore and Rockville, Maryland, and at HCFA's Atlanta regional office. We attempted to determine the extent to which these agencies monitored the four Florida HMOs for compliance with federal requirements relating to financial solvency; quality assurance; payment of provider bills; marketing practices; and Medicare enrollees' grievance and appeal rights. Also, we sought to learn the extent to which significant issues raised by HCFA and OHMO through their oversight activities were addressed and how or whether they were satisfactorily resolved at the completion of our fieldwork in October 1985.

To determine how the four Florida HMO operations were regulated and monitored, we also reviewed records and interviewed officials of the Florida Department of Insurance and the Florida Department of Health and Rehabilitative Services. We did not attempt to evaluate the effectiveness of their activities, but developed information on their roles and responsibilities in monitoring HMO activities and the results of the monitoring.

At each of the four Florida HMOs, our review focused on their contractual, financial, and Medicare enrollee records. We sought to (1) determine HMO grievance and appeals procedures and learn if Medicare enrollees' rights were being adequately protected, (2) assess marketing

practices under HMO demonstrations, and (3) determine contractual and financial arrangements with providers. We visited the principal HCFA intermediary and carrier for Florida (Blue Cross/Blue Shield) in Jacksonville and Ft. Lauderdale and reviewed Medicare beneficiary records for selected enrollees of these HMOs. We performed our fieldwork between April 1984 and October 1985.

To assess the reasonableness of AAPCC payment levels established by HCFA, it was necessary to estimate how much it would cost in the fee-for-service sector to provide Medicare services to a given group of beneficiaries that actually enrolled in a particular HMO. This could not be determined directly because HMO enrollees in fact were not in the fee-for-service sector. Consequently, to assess the reasonableness of AAPCC rates we had to rely on an indirect measure, mortality rates. We compared actual and actuarially predicted mortality of those enrolled in 27 pre-TEFRA risk-based HMOs.[8] This analysis was done because HCFA has reported that on average it costs Medicare 6.2 times more to provide health care services to beneficiaries in their last year of life than for services to those who survive (see p. 62). To the extent that mortality rates of those enrolled in HMOs are substantially lower or higher than Medicare averages, payments based on Medicare average costs would be too high or too low because of the under- or over-representation of enrollees in their last year of life.

For each of the 27 HMOs, we obtained its 1984 enrollment and the age and sex of enrollees from HCFA's 1984 Group Health Plan Master Record (HCGPMST) file. We used national age- and sex-specific mortality tables prepared by our actuaries to determine, by months of enrollment, total projected mortality among the HMOs' enrollees. To calculate actual mortality, we used the mortality code on the HCGPMST file. Using actual and projected mortality, we calculated the adjustment to the percentage of the present risk-based payment levels that would result in the risk-based HMO program costing no more than traditional fee-for-service. Details of the algebraic methods we used are presented in appendix I.

We assessed two other factors that could affect the adequacy of AAPCC payments: (1) the potential for the four HMOs in Florida to screen—assess health status of applicants prior to enrollment—in order to limit the enrollment of less healthy applicants and (2) the utilization of part A services following disenrollment for the 27 HMOs to determine whether

[8]We excluded 5 of the 32 risk-type demonstration HMOs for which data were available because they had become operational late in 1984, and the data base was too small for reliable analysis

those who left the HMOs were higher users of hospital services than Medicare averages.

Florida Blue Shield, the principal Medicare carrier for Florida, gave us part B data on services provided between October 1982 and June 1984 to Medicare beneficiaries who enrolled in the four Florida HMOs. We used these data to calculate by HMO the percent of HMO enrollees who received a part B service during the month preceding their effective enrollment date. Additionally, we used these data to array allowed charges by provider to determine for each of the four Florida HMOs the top five providers that billed Medicare for the highest dollar volume of services. For these providers, we reviewed a 2-percent sample of the HMOs' services to pre-enrollees to determine the types of services and whether they provided an indication of potential HMO screening (e.g., whether they involved a battery of routine diagnostic tests, such as a chest X-ray and electrocardiogram).

We studied postdisenrollment part A utilization during the 3-month period immediately following disenrollment for the 27 risk-based HMOs by first identifying on HCFA's 1984 HCGPMST file each beneficiary who disenrolled between October 1, 1983, and June 30, 1984. Then, using the beneficiary health insurance claim number, we matched these disenrollees with the HCFA 1984 Stay File (which contains information on part A bills and Medicare payments) to create a file of 3-month part A utilization and reimbursement data. We selected the 3-month period for analysis under the assumption that, if there was a pattern of higher or lower users of services disenrolling from HMOs, it would be apparent in a relatively short time. This file was used to calculate part A postdisenrollment statistics and to provide demographic information on disenrollees. Using these data, we computed the difference between the Medicare cost and what Medicare would have paid under the AAPCC had the disenrollees remained in the HMO.

We performed our review in accordance with generally accepted government auditing standards.

Federal and State Oversight Activities Leave Unresolved Issues

Various federal and state agencies had oversight responsibility for the four Florida demonstration HMO projects at the time of our review. At the federal level, two HHS agencies—HCFA and OHMO[1] —were charged with assuring HMO compliance with Medicare and PHS laws and regulations concerning HMO payment rates, enrollment and disenrollment, financial solvency, and quality of care. In Florida, two state agencies had HMO oversight responsibilities—the Departments of Health and Rehabilitative Services (HRS) and Insurance. These agencies had jointly developed rules for HMO licensing that related primarily to financial solvency, consumer protection, and quality of care.

During the course of their oversight activities, the state and federal agencies identified and in most cases resolved numerous issues involving HMO quality assurance systems, payment of hospital bills, marketing practices, and financial solvency. In this chapter, we discuss the resolution of these issues to provide perspective on the nature and scope of federal and state oversight activities.

But four important issues raised by HCFA and OHMO oversight activities, all concerning IMC, were neither resolved nor adequately addressed by the time we completed our fieldwork in October 1985:

- IMC's slow payment of provider bills, which could adversely affect the accessibility and availability of covered services to members (discussed in this chapter).
- IMC's difficulty in complying with Medicare's requirement that no more than 50 percent of an HMO's enrollees be Medicare and Medicaid beneficiaries, to help ensure quality of care at HMOs.
- IMC's practice of contractually transferring much of its financial risk for enrollees' health care to affiliated health care providers, which are not subject to the same financial and quality-of-care safeguards as HMOs. (OHMO expressed concern over this in its March 1985 qualification approval of IMC as discussed in chapter 3.)
- Some of IMC's affiliated providers ". . . are actively recruiting and enrolling new members . . . [and] are undoubtedly screening potential enrollees and more actively recruiting those who are in good health," an OHMO reviewer commented in a report after a qualification review site visit preceding the March 1985 qualification approval. Medicare does

[1]OHMO responsibilities were transferred to HCFA on March 14, 1986, as noted on p. 18 Because at the time of our review these agencies' functions were separate, we deal with them separately in this chapter

not permit such practices as they can result in HMOs receiving excessive Medicare payments (discussed in chapter 4).

Also unresolved is the matter of how to use PROs in reviewing HMOs to help assure the maintenance of high quality-of-care standards. Although HCFA intended to expand PRO contracts in 1985 to include an HMO review, this function was not included in the revised PRO scope of work issued December 1985, reportedly because of budgetary considerations.

Problems Resolved Through HCFA Oversight

HCFA regulates and monitors HMOs' compliance with Medicare laws and regulations. During the demonstration program, HCFA selected the HMOs allowed to participate; also, through its monitoring, HCFA identified and dealt with numerous problems involving HMO enrollment and disenrollment procedures, slow payment of provider bills, and misleading or otherwise inappropriate marketing practices.

Helping administer the Medicare HMO demonstration projects were two HCFA organizational units—the Office of Research and Demonstrations, which reported directly to the HCFA Associate Administrator for Policy, and the Group Health Plan Operations (GHPO) unit within the Bureau of Program Operations. Specifically, through these offices, HCFA

- selected the HMOs that would participate in the demonstration projects and approved operating protocols and waivers to the regulations;
- reviewed and approved prior to publication the HMOs' marketing materials and information (such as handbooks) provided to Medicare beneficiaries;
- awarded and administered evaluation contracts, with the principal contract being granted to Mathematica Policy Research, Inc., for a 4-year study of HMOs to be completed in June 1988;
- provided guidance in interpreting HHS regulations to other HCFA components and to HMOs;
- processed the enrollments and disenrollments from the HMOs for posting to HCFA's Health Insurance Master File;[2] and

[2]HCFA maintains a Health Insurance Master File, which indicates if Medicare beneficiaries are enrolled in an HMO. For risk-type HMOs, the file's accuracy is particularly important to preclude the paying agents from (1) making "duplicate payments" for services provided to Medicare beneficiaries that were covered by the HMOs' capitation payments and (2) incorrectly denying claims for beneficiaries after they have disenrolled. Problems in maintaining this file were discussed in our March 8, 1985, report (GAO/HRD-85-48) and are discussed in chapter 5 of this report.

- coordinated the HMO operations with the Medicare contract paying agents (intermediaries and carriers) and paid the HMOs based on the capitation rates developed by HCFA's Office of the Actuary.

In April 1985, the HCFA regional offices, along with GHPO, assumed primary responsibility for monitoring HMO operations under TEFRA. The Office of Research and Demonstrations was no longer directly involved in the programmatic aspects of federal HMO oversight.

Since the beginning of the four HMO demonstration projects (and, in the case of IMC, under the prior risk contract), HCFA has received and reacted to complaints from beneficiaries, providers, and others about the HMOs' activities. These matters, concerning marketing practices, payment of hospital bills, and premiums charged to HMO enrollees, provide insight on the scope, nature, and consequences of HCFA's oversight activities, as discussed below:

- In November 1982 (about 1 month after CAC's demonstration project began), the Dade County Medical Association, local officials, and HCFA raised questions about CAC's mass mailing of marketing and enrollment materials, which indicated that the federal government was supporting its particular plan. The medical society initiated a lawsuit on the matter. Although CAC officials contended HCFA approved the materials, the controversy was resolved when HCFA required that any beneficiary that had responded to CAC's solicitation was not to be enrolled in the HMO until CAC had contacted the individual and fully explained the provisions of its plan.
- In another instance in November 1983, HCFA through prior review of AV-MED marketing materials identified several incorrect statements about the nominal ($5 per visit) copayment for physicians' visits. The information could have misled enrollees into believing that all the HMO's services were provided without charge. HCFA required that this be clarified and the phrase "The U.S. Government is behind AV-MED" be deleted because the phrase could mislead Medicare beneficiaries in implying federal sponsorship.
- HCFA intervened in south Florida, also in 1983, in response to allegations that some hospitals were refusing to accept the Medicare allowable rate as full payment when an HMO paid the claims. To resolve this controversy, HCFA developed an alternative payment procedure under which the Medicare intermediary in Florida would pay hospital bills on behalf of the HMO (when the HMO did not have a specific payment agreement with a hospital), and such payments would be deducted from HCFA's

payment to the HMOs. Three of the four HMOs (IMC, AV-MED, and HealthAmerica) elected to use this payment option.

- In May 1985, AV-MED filed a request with the Florida Insurance Commissioner to charge its Medicare enrollees in the Tampa Bay area a premium of $45 a month to cover a perceived shortfall between the cost of providing services in that area and the capitation rates paid by HCFA. Because charging a premium was not specified in the HMO's Medicare contract, HCFA intervened. The issue was resolved when AV-MED withdrew its proposal.

HCFA Monitoring: Some Issues Remain

The unresolved issues we identified when reviewing HCFA's monitoring activities related to IMC's (1) payment of provider bills and (2) adherence to the required enrollment mix of no more than 50 percent Medicare and Medicaid enrollees. Although HCFA, when it entered into the demonstration contract with IMC, had established a payment performance standard, IMC did not adhere to it. Timely payment of providers is necessary to assure Medicare enrollees continued access to services. Consequently, HMOs should be held to timeliness of payment standards comparable to those of the Medicare paying agents.

Concerning the enrollment mix, Medicare beneficiaries represented about 69 percent of IMC's enrollment as of April 1, 1985, and in 1985 IMC continued to enroll more Medicare than non-Medicare members. Thus, it was questionable whether IMC could meet the standard within the expected 3-year period, and HCFA did not ask IMC to provide information so that HCFA could monitor IMC's progress in meeting the standard. Because of concerns over quality of care, the Congress clearly did not want the development of HMOs that predominately serve Medicare beneficiaries.

IMC: 3-Year History of Slow Claims Payments

The HMOs' arrangements for providing health services to their enrollees and how these arrangements affect the providers, e.g., doctors and hospitals, constituted an issue we were asked to address. Slow payment of provider bills or claims can adversely affect enrollees' access to and the availability of services. Physicians who are not paid on time can become unwilling to accept enrollees referred to them.

HCFA had tentatively resolved IMC's slow payment problem by setting up a payment performance standard when it entered into the demonstration contract with IMC, but did not include the solution in the contract or effectively follow up on those arrangements.

Just before HCFA signed the demonstration contract with IMC (in July 1982), HCFA's Atlanta regional office and various private sources advised the agency that it should not sign until IMC showed improved performance under its existing section 1876 risk-based contract. This advice was based on concerns about (1) IMC's enrollment and disenrollment practices and related problems experienced by providers in identifying IMC members, (2) IMC's nonpayment of bills for its members, whether services were authorized or not, and (3) coordination problems between IMC and the Medicare intermediary in the payment of hospital bills. Because HCFA had approved IMC's participation in the demonstration project in March 1982 and the extent of these concerns did not surface until shortly before the scheduled contract signing, HCFA decided not to follow the advice.

Instead, to resolve these operational problems, HCFA developed a plan in the form of a "Summary of Agreements" that HCFA gave IMC along with the executed contract by letter dated July 23, 1982. The summary contained nine items, among them (1) plans for IMC to pay its existing backlog of hospital and doctor bills, (2) assistance from IMC to providers through improved identification of members, (3) agreements that IMC would improve beneficiaries' education on the "lock-in" provision by having nonsalespeople interview enrollees by telephone before sending their enrollments to HCFA for processing, and (4) standards for timely payment of claims. Although HCFA said it might terminate the contract if IMC did not adhere to the agreements, the summary was not made part of the contract. Except for not meeting the timeliness of payment standard, either IMC adopted the improved procedures or the concerns precipitating them became somewhat moot with the passage of time.

The payment standard provided that IMC would pay claims twice each month (on the lst and 15th). Any claim containing information sufficiently complete to permit payment and received 5 working days before the next scheduled payment day would be paid on that payment day. This was to result in about one-third of the claims being paid within 10 days of receipt, one-third within 15 days, and the remaining one-third within 21 days. This standard appeared reasonable because, at the time, the principal carrier in Florida (Florida Blue Shield) was processing about 95 percent of its bills within 15 days of receipt, and the principal intermediary (Blue Cross) was processing about 98 percent of its bills within 30 days of receipt.[3]

[3]As part of its contractor performance evaluation program, HCFA establishes timely payment standards for carriers and intermediaries For example, in 1985 HCFA standards provided that within 30

Apparently HCFA was not enforcing this payment standard. According to IMC personnel, as of July 1985, IMC did not maintain detailed statistics on processing times for paid claims. However, in May 1985 it began keeping statistics on the age of the pending claims. Based on IMC statistics for the period May through July 1985, it was not meeting the payment standard of processing all claims within 21 days of receipt, although 3 years had elapsed since its agreement with HCFA to do so. IMC hospital and physician claims received, processed, and pending at the end of the month for May, June, and July 1985 are shown in table 2.1, along with the number of days outstanding (on average) and the dollar amounts pending. Claims under medical review were excluded.

Table 2.1: IMC Claims Received, Processed, and Pending

	Claims		Claims pending at end of month		
Month (1985)	Received	Processed	No.	Average age (days)	Amount (thousands)
May	21,596	27,714	31,964	51 8	$12,636
June	27,901	30,844	29,021	48 1	11,343
July	48,259	54,981	22,299	29 4	16,759

Slow payment of claims can adversely affect the accessibility and availability of covered services to HMO members. During our review, there were reports that medical specialists, such as anesthesiologists, refused to provide services to IMC members because they were not being paid on a timely basis. According to HCFA Atlanta regional office officials, the resolution of IMC's slow payment of claims was a priority in the regional office.

IMC's Enrollment Mix Questionable

The requirement that not more than 50 percent of an HMO's enrollment may be Medicare and Medicaid beneficiaries appears in section 114(a) of TEFRA. But the regulation implementing this provision (417.413(d)) permits the composition of enrollment standard to be waived if (1) the HMO is making reasonable efforts to enroll non-Medicare or non-Medicaid beneficiaries or (2) these public program beneficiaries constitute more than 50 percent of the population of the HMO's geographic area. The latter is defined as the area within which the organization furnishes or arranges to furnish the full range of services it offers to its Medicare enrollees, as determined by HCFA.

days intermediaries pay 95 percent of hospital inpatient bills and carriers pay 85 percent of physician bills

There also can be exceptions to the 50-50 composition-of-enrollment standard for organizations such as the four Florida HMOs, which were demonstration projects at the time they applied for a TEFRA contract. This exception applies for a period up to 3 years or longer (to be determined by HCFA before the expiration of the 3-year period) if circumstances indicate that it is in the best interest of the Medicare program to continue the exception.

The purpose of the 50-50 provision is to help assure quality of care. The legislative history of the provision dates back to the Social Security Amendments of 1972, which included a similar provision, indicating that the Congress wished to limit participation to HMOs that were substantially established ". . . with reasonable standards for quality of care at least equal to standards prevailing in the HMO area . . ." Additionally, the House Committee report on the Medicare/Medicaid HMO Amendments of 1981 that preceded the enactment of TEFRA concluded that the provision evolved from Medicaid's prepaid health plan experience of the 1970's, which generally involved "Medicaid-only" HMO-type organizations. In these health plans, the Congress was concerned about the adverse quality implications of Medicaid-only HMOs, especially the tendency to underserve enrollees. Accordingly, including a substantial portion of privately insured individuals in an organization would provide a safeguard to better assure quality care, and under TEFRA the Congress did not provide for "Medicare-only" HMOs.

Under the Florida demonstrations, the enrollment mix standard was no more than 75 percent Medicare/Medicaid enrollees. Except for IMC and AV-MED in the Tampa Bay area,[4] meeting this standard was not a problem because, in three of the four HMOs, enrollments were predominately commercial. The composition of enrollment when the Florida demonstrations were converted to TEFRA is shown in table 2.2.

[4]Effective September 30, 1985, AV-MED notified HCFA that it would not renew its Medicare HMO contract in Tampa Bay when it expired in December 1985 reportedly because, in its view, Medicare payment rates were too low for this market area.

Table 2.2: Florida HMOs' Medicare/ Non-Medicare Enrollment Upon Conversion to TEFRA

	Enrollment					
	Medicare		Non-Medicare		Total	
HMO	No.	Percent	No.	Percent	No.	Percent
IMC	125,219	69	55,583	31	180,802	100
AV-MED	11,434	14	68,069	86	79,503	100
CAC	6,324	14	38,613	86	44,937	100
HealthAmerica	2,763	15	15,348	85	18,111	100
Total	**145,740**	**45**	**177,613**	**55**	**323,353**	**100**

On April 4, 1985, HCFA granted IMC a 3-year waiver to the 50-50 enrollment standard in all the counties it served and to AV-MED in the service area of Hillsborough, Pinellas, Pasco, and Manatee counties (Tampa Bay area). The waivers did not define a specific enrollment standard. In early May 1985, HCFA asked the two HMOs to outline their strategies for increasing their non-Medicare membership during the next 3 years. It also limited the waiver to the geographic areas in which the HMOs operated during the demonstration projects.

An attorney for IMC wrote HCFA on May 30, 1985, pointing out that, in accordance with the regulations, HCFA did not waive the 50-50 requirement, but rather made an exception to the requirement. Therefore, the attorney concluded, HCFA had (1) made a finding that the HMO was making a reasonable effort to enroll individuals who were not Medicare or Medicaid beneficiaries and (2) established the 3-year period of the exception. Accordingly, the attorney said that:

" . . the regulation neither gives HCFA the authority to monitor the continued reasonable efforts of the organization, nor to withdraw the exception once it has been granted by HCFA "

In addition, the attorney stated that the exception applied to the organization as a whole, not just the areas operated under the demonstration.

HCFA responded on August 26, 1985, that under the exception, it expected an HMO to progressively work toward compliance with the composition of enrollment standard. At the conclusion of the 3-year period, HCFA said, it expected the 50-percent enrollment composition requirement would have been met. Significantly, HCFA did not repeat its request for a strategy outlining how IMC was going to accomplish this. Also, HCFA agreed with IMC that the exception was not limited to areas included in the demonstration, but would extend to any other areas where IMC was qualified to operate.

Prior to enactment of TEFRA, both the Social Security Act and the implementing regulations required an HMO to submit annual plans to HHS detailing its progress in meeting the standard when a waiver was granted. TEFRA amended the Act so that this annual submission was no longer required.

Nevertheless, HCFA has recently taken some positive steps to resolve the problem. In February 1986, HCFA notified IMC that the exception would only apply to areas it served during the demonstration and also advised IMC that it would monitor IMC's progress in meeting the 50-50 standard. Additionally, in March 1986, the Atlanta regional office notified IMC that it must submit a plan by the end of April detailing its strategy for enrolling more commercial than Medicare members. IMC submitted its plan in April. In May 1986, HCFA requested additional information because the plan IMC submitted was not specific enough.

On June 6, 1986, HCFA informed IMC that, because IMC's composition of enrollment had not varied significantly since the exception was granted (April 1985), HCFA believed that IMC's ". . . contract should be modified to include explicit milestones for achieving compliance with the enrollment standard and sanctions for failure to meet them, including a moratorium on further Medicare beneficiary enrollment." HCFA also reserved the right to terminate IMC's exception to the enrollment standard. On June 12, 1986, IMC announced that it was temporarily placing a cap (137,500) on the number of Medicare beneficiaries it would serve.

HCFA is also taking steps to develop intermediate level sanctions, other than terminating an HMO's contract, for when an HMO is not abiding by its contract provisions. However, HCFA officials told us that it will need legislative authority to implement additional sanctions and plans to seek such authority.

HCFA's recent actions to more closely monitor IMC's progress in meeting the 50-50 goal are appropriate, we believe. Based on 1985 actual and projected enrollments, IMC will have difficulty meeting the goal by March 31, 1988, when its exception to the requirement expires, particularly in the Tampa Bay service area. IMC's enrollment statistics for January and June 1985 are shown in table 2.3, along with its projected enrollment for December 1985 for its affiliates by service area and for the wholly owned IMC clinics (mostly in Dade county). The percentages of Medicare and non-Medicare enrollees also are shown.

Table 2.3: IMC's Medicare/Non-Medicare Enrollment, Actual and Projected (1985)

	Enrollees in affiliated and wholly owned centers, by service area													
	Dade		Broward		Palm Beach		Tampa Bay		Subtotal		IMC-owned clinics		Grand total	
Period	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
January 1985 (actual):														
Medicare	12,251	61	26,022	76	22,439	88	40,528	85	101,240	79	11,298	33	112,538	70
Non Medicare	7,879	39	8,028	24	3,050	12	7,398	15	26,355	21	22,990	67	49,345	30
Total	**20,130**	**100**	**34,050**	**100**	**25,489**	**100**	**47,926**	**100**	**127,595**	**100**	**34,288**	**100**	**161,883**	**100**
June 1985 (actual):														
Medicare	15,676	61	28,407	76	23,737	84	44,414	83	112,234	77	11,065	35	123,299	70
Non Medicare	9,879	39	9,095	24	4,648	16	9,046	17	32,668	23	20,538	65	53,206	30
Total	**25,555**	**100**	**37,502**	**100**	**28,385**	**100**	**53,460**	**100**	**144,902**	**100**	**31,603**	**100**	**176,505**	**100**
December 1985 (projected):														
Medicare	21,834	62	30,986	74	22,782	72	56,890	81	132,492	74	12,098	34	144,590	67
Non Medicare	13,443	38	10,969	26	8,951	28	12,988	19	46,351	26	23,795	66	70,146	33
Total	**35,277**	**100**	**41,955**	**100**	**31,733**	**100**	**69,878**	**100**	**178,843**	**100**	**35,893**	**100**	**214,736**	**100**
Net increase, 1985:														
Medicare	9,583	63	4,964	63	343	5	16,362	75	31,252	61	800	50	32,052	61
Non Medicare	5,564	37	2,941	37	5,901	95	5,590	25	19,996	39	805	50	20,801	39
Total	**15,147**	**100**	**7,905**	**100**	**6,244**	**100**	**21,952**	**100**	**51,248**	**100**	**1,605**	**100**	**52,853**	**100**

About one-third of IMC's non-Medicare enrollment is concentrated in its original wholly owned staff clinics, as table 2.3 shows. Also, although the percent of Medicare enrollees decreased by 3 percent in 1985, their absolute number increased more rapidly than the absolute number of non-Medicare enrollees. If the Medicare/non-Medicare enrollment activity in 1985 is typical, then IMC will not reach the 50-50 standard by March 31, 1988.

Another factor adding to the uncertainty of IMC reaching the 50-50 enrollment standard is that the affiliated providers and the IMC centers were losing money on their commercial contracts. We base this statement on our review of IMC internal audit reports and the material supporting OHMO's March 1985 qualification review. If IMC raises its commercial rates to overcome these losses, however, this could adversely affect IMC's competitive position for enrolling more commercial members.

Irrespective of whether IMC has a "waiver" or an "exception," HCFA needs to resolve the composition-of-enrollment issue before the waiver/exception expires. To the extent that IMC does not take actions that

result in reasonable progress toward compliance, an enforcement action such as a moratorium on Medicare and Medicaid enrollments would be appropriate. Otherwise, the statutory composition-of-enrollment standard has been rendered virtually meaningless for IMC, the largest Medicare HMO in the country.

OHMO Resolves Most Compliance Issues

Within OHMO, two organizational units regulated or monitored HMO activities under title XIII of the PHS Act. The Division of Qualification reviewed applications by HMOs to be qualified under the act, and the Division of Compliance reviewed HMO compliance with the act after qualification.

The qualification process could involve an initial qualification for a new HMO or an expansion of a qualified HMO into a new area. When reviewing an application, the Division of Qualification examined and evaluated five factors:

- Management, e.g., experience and qualifications of key staff and the nature of the HMO's management information systems.
- Financial, e.g., adequacy of financing, reasonableness of financial projections, and whether assets exceeded unsubordinated liabilities and there was a positive net worth.
- Marketing, e.g., competition in the area, targeting of specific employer markets, and skills of the marketing staffs.
- Legal, e.g., compliance with federal and state requirements, contractual arrangements with providers, and adequacy of insurance.
- Health services, e.g., utilization control practices, quality assurance programs, and the availability, accessibility, and continuity of services.

After reviewing an application, the division visited the HMO with a team of experts covering all five components. The team, which would include OHMO personnel and consultants who usually worked for already qualified HMOs, then prepared a report on each of the five components. Using these reports, the division developed a final recommendation to either (1) qualify the HMO, (2) issue an intent to deny qualification (after which the HMO had 60 days to address the deficiencies), or (3) issue an outright denial (after which the HMO could request a reconsideration).

During our review, the OHMO Division of Qualification qualified IMC in the Broward, Palm Beach, and Tampa Bay areas and AV-MED in the Tampa Bay area. Also, in March 1985, it approved an expansion of HealthAmerica into additional areas in Dade and Palm Beach counties

and, in May 1985, the expansion of CAC's service area to include Broward county.

After an HMO was qualified, the Division of Compliance reviewed it to assure that it continued to meet the requirements for qualification. According to OHMO personnel, a principal activity was examining qualified HMOs for continued financial soundness, but the division also might become involved in other areas as a result of complaints or other sources of information.

All four Florida HMOs were evaluated for compliance with OHMO requirements during the periods they were HCFA demonstration projects. Most of the compliance issues were eventually resolved, e.g .

- HealthAmerica was under evaluation from April 1984 to March 1985 for compliance with a number of federal OHMO requirements involving (1) availability, accessibility, and continuity of health services (resulting from patient complaints of long waiting times and unavailability of physicians), (2) lack of documentation and procedures for taking remedial actions in its quality assurance program, and (3) effects of operating losses and a negative working capital on its financial stability. All these issues were resolved.
- OHMO began evaluating CAC in January 1984 for compliance with federal HMO requirements in connection with its practice of permitting certain enrollees (including Medicare members) to obtain reimbursable services from nonaffiliated doctors without authorization from the HMO. This unallowable "freedom of choice" issue was resolved when CAC agreed to phase out this benefit from its contracts for non-Medicare members and to require Medicare members to obtain from CAC prior verification of the medical necessity of such services.
- IMC was found in noncompliance by OHMO in July 1984 for not having an adequate plan for handling insolvency. The issue was resolved when IMC deposited $5 million in trust and subsequently obtained insurance to protect itself from insolvency.
- OHMO began evaluating AV-MED in January 1985 for compliance with requirements for an ongoing quality assurance program. OHMO visited AV-MED in April 1985, and in April 1986, the Division of Compliance determined that AV-MED's quality assurance program complied with the regulations.

Additionally, on April 4, 1986, OHMO reevaluated IMC's qualification, focusing on its administrative and managerial arrangements and quality assurance program. This was done apparently because of concerns

arising from recent allegations about the HMO's financial solvency, quality of care, and overall management. As a result, on May 30, 1986, HCFA notified IMC that it lacked satisfactory administrative and managerial arrangements or an acceptable ongoing quality assurance program to meet the requirements of the PHS Act. HCFA directed IMC to submit, within 30 days, a proposal for a time-phased corrective action plan to address the deficiencies it identified. Because OHMO's evaluation addresses issues also discussed in this report dealing with timeliness of payments, IMC's organizational structure for delivering services (chapter 3), and the need for better quality assurance mechanisms, we have included the May 1986 letter summarizing OHMO's findings as appendix II.

In the process of doing its earlier qualification and compliance reviews, OHMO personnel identified two issues that we feel they did not satisfactorily resolve. We address these two issues, the financial qualifications of IMC's affiliated providers and potential screening of new enrollees, in chapters 3 and 4, respectively.

Peer Review Organizations Play Limited Role

Peer review organizations contract with HCFA to monitor the utilization and quality of services to Medicare beneficiaries, usually in an inpatient hospital setting. Throughout much of 1985, HCFA worked with PROs and HMOs to develop procedures for reviewing the HMO's quality of care. Although HCFA originally intended to introduce an explicit PRO review program in 1985, it did not do so.

Before the implementation in October 1983 of Medicare's new prospective payment system (PPS) for inpatient hospital services, PROs (then referred to as PSROs—Professional Standards Review Organizations) focused on "concurrent review" of the length of stay of Medicare patients. This was because, under Medicare's previous cost-based reimbursement system, there was little incentive to discharge patients on a timely basis. The PSROs' findings on appropriate lengths of stay were usually binding for reimbursement purposes. For risk-type HMOs, however, there was already an incentive for timely discharges of Medicare patients. Medicare's capitation payments to HMOs based on the AAPCC rate normally would not be affected by any PRO findings as to length of hospital stay of HMO members.

From our interviews with a former PRO official in south Florida and with an HMO official, we perceived that PROs had no continuing involvement with the Florida projects during the early phases of the demonstration

project. According to a HCFA official, however, this may not have been entirely correct. If a PRO was reviewing quality of care at a particular hospital, using a sample of Medicare patients, HMO patients could have been included in the sample, but the PRO reviewer probably would not know this.[5]

In July 1984, HCFA contracted with a Tampa organization to operate a PRO for the state of Florida for the period August 1, 1984-July 31, 1986. In recognition of the changes in incentives that PPS brought about in use of hospital services and because Medicare now pays on the basis of admissions, this contract focused on appropriateness of admissions and quality of services rather than on length of stay. Under the quality objectives, the PRO contract also stressed avoiding readmissions due to substandard quality of care. But we found nothing in the contract specifically related to HMO Medicare hospital patients alone, even though they may have been included in the statistics used to set the PROs' quality objectives, and Medicare enrollees' hospital stays were not exempt from PRO review.

HCFA recognized that, because of the way it pays risk-type HMOs, they also have incentives to avoid hospital admissions. Therefore, since January 1985, HCFA had been working with the PROs and HMOs to develop review procedures consistent with the incentives in the HMO payment system. Because the HMOs are capitated for both physicians' and hospital services, it was intended that any proposed PRO review would look at both hospitalizations and the HMOs' patient care practices prior to those hospitalizations. In addition, HCFA planned to involve HMO practicing physicians, contracted by the PROs, in performing the reviews. This would help assure that HMOs were reviewed in accordance with prevailing HMO industry standards.

But HCFA, reportedly because of budgetary considerations, did not include a PRO review function for HMOs in its revised scope of work for PROs issued in 1985. The issue of whether or how to involve PROs in HMO reviews is still unresolved. However, the 1985 Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272), enacted April 7, 1986, specifically authorizes HMO peer reviews to begin on January 1, 1987. HCFA has not indicated how it will implement this provision.

[5]Additionally, in one case involving CAC, HCFA requested a PRO in Florida to review a complaint After investigating, the PRO issued a report critical of the HMO's medical records system. A corrective action plan was instituted, and CAC revised its record system

Two State Agencies Oversee HMOs

Two Florida state agencies[6] regulate and monitor HMO operations: the Department of Insurance and HRS. They have jointly developed rules for licensing and regulating HMOs in the state under chapter 641, part II, of the Florida Statutes. We met with officials from the agencies, but did not attempt to evaluate the effectiveness of their monitoring activities. We developed information on agencies' roles and responsibilities in monitoring HMO activities and results of the monitoring.

Department of Insurance Licenses, Monitors HMOs

With respect to HMOs, the principal activities of the Department of Insurance are issuing certificates of authority (which in effect license them to do business in the state) and monitoring their continued financial solvency. In addition, the department has responded to enrollee complaints and monitored HMO advertising.

State law requires the department to examine the affairs, transactions, business records, and assets of each HMO at least every 3 years or more frequently at the Department's discretion. Although the examination of IMC raised some concerns about its financial solvency, the issues were resolved as follows:

- For the period ended September 30, 1983, IMC had canceled its reinsurance policy covering insolvency protection and established a segregated bank account in its own name. This procedure was not in accordance with state law; subsequently, IMC obtained a reinsurance policy and deposited $140,000 with the state to resolve the matter.
- In September and October 1984, the department made another examination because of concerns over unsecured loans made to a related organization (Miami General Hospital) and to officers and directors of IMC. The loans were shown as assets on the HMO financial statements. These concerns were resolved when (1) IMC acquired 80 percent of the stock of the hospital for $4.8 million, reducing the amount due from the hospital by the same amount, and (2) the officers and directors repaid $1 million in loans.

No financial solvency issues were raised by the state concerning CAC, HealthAmerica, or AV-MED.

[6]The Florida Department of Professional Regulation does not regulate or monitor HMOs as such It handles complaints concerning the licensure status of licensed personnel employed or used by the HMOs In April 1985, we were told by a department official that the department had handled eight complaints involving the four HMOs since the demonstration projects began The agency's investigation of these complaints revealed no licensure violations

Department of Health and Rehabilitative Services Monitors Care

HRS monitors the quality of care provided by HMOs. This includes investigating complaints and making annual surveys to determine whether an HMO meets minimum standards for providing quality care.

At the department's Miami office, we identified 25 complaints involving Medicare enrollees at the four demonstration HMOs and reviewed their investigation and disposition. The complaints covered the period from the beginning of the demonstration projects through February 1985. In 8 cases, the HRS investigations partially or fully confirmed the allegations, e.g.:

- A complaint that CAC was violating state law by holding patients in the emergency room at one of its clinics for more than 24 hours was confirmed. In March 1984, CAC advised HRS that the HMO had instituted a policy to preclude holding patients for more than 15 hours.
- In response to another complaint, HRS concluded that an individual performing eye examinations at an IMC clinic was not licensed in Florida as an optometrist. IMC subsequently advised HRS that the individual's services had been discontinued.[7]
- A hospital administrator in Broward county complained about delays in admitting IMC patients through the hospital emergency room because the hospital staff was unable to contact IMC for approval. HRS advised the hospital that in emergency situations HMO approval of an admission was not required.

HRS also performed annual surveys to review the quality of care provided by HMOs. These surveys included, but were not limited to, evaluations of HMOs' internal and external peer review processes, grievance procedures, suitability of staff and facilities for providing medical services, medical record systems, and compliance with state law and regulations.

A review of the most recent HRS surveys at the four HMOs revealed that deficiencies generally related to quality assurance procedures involving the peer review process, i.e.:

- IMC (September 1984). IMC did not conduct internal peer reviews on a continuous basis, HRS found. Disagreeing, IMC provided evidence that it

[7]Apparently, this case was not referred to the Florida Department of Professional Regulation because, as discussed on p 38, the department had no record of licensure violations by any of the four Florida HMOs

was in compliance. (HRS apparently accepted the evidence; they took no further actions.)

- AV-MED (January 1985). External peer review was not conducted by non-HMO medical staff, according to HRS. AV-MED filed a plan of corrective action. According to AV-MED, external peer reviews were conducted by the University of Miami's non-HMO medical staff in February 1985 and May 1986.
- CAC (January 1985). No citable deficiencies were found.
- HealthAmerica (January 1985). HRS found no arrangements for external peer review to be conducted by physicians outside the HMO staff or for written medical staff by-laws. HealthAmerica filed a plan of corrective action.

Conclusions

Although it has identified and resolved many significant issues arising out of the HMO demonstration projects, HCFA did not follow through on two long-standing issues it deemed significant.

One issue involves IMC's slow payment of provider bills, which was tentatively resolved in July 1982 when HCFA established for IMC a reasonable performance standard for paying such bills. For over 3 years, however, the standard was apparently not enforced by HCFA, and IMC was not meeting it. The standard should have been included in the contract and enforced from the outset, we believe. The timely payment of providers' claims is important for gaining non-HMO provider support to assure beneficiary access to covered services. To avoid such problems in other HMOs, HCFA needs to develop a timeliness-of-payment standard for HMOs similar to that now imposed on Medicare's paying agents.

The other issue involves IMC's failure to meet the 50-50 enrollment mix requirement. HCFA deferred a solution initially by granting IMC an exception and later by requesting that IMC submit a strategy for increasing commercial membership faster than Medicare and Medicaid memberships. IMC continued, however, to enroll more Medicare members than non-Medicare members during the time of our review. Therefore, to the extent that this continues, the HMO will not meet the requirement when its present exception expires in March 1988. As the requirement is contained in the law, HCFA should take action to assure that IMC is making reasonable progress toward compliance.

With respect to involvement of PROs in reviewing HMO utilization and quality of care, HCFA should resolve this issue also. PROs' present role, which only peripherally involves HMO Medicare beneficiaries who may

be selected in a PRO sample of hospital admissions, provides little assurance that HMO Medicare enrollees will be identified as such and no continuing mechanism for reviewing the quality of care by the HMO. The 1985 Consolidated Omnibus Budget Reconciliation Act, which specifically authorizes HCFA to develop an HMO PRO review program, should give HCFA the impetus to establish such a program.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to (1) assure that IMC is making reasonable progress in meeting the 50-50 composition of enrollment standard or take enforcement action if IMC is not making such progress; and (2) develop an HMO timeliness-of-payment standard either through regulations or by including it as a standard item in all Medicare HMO contracts.

Agency Comments and Our Evaluation

In commenting on our first recommendation, HHS stated that it is monitoring very closely IMC's actions to come into compliance with the 50-50 composition-of-enrollment requirement (see app. IV). HHS outlined the recent actions it has taken, and we have updated the report to recognize these actions. HHS also advised us that it is taking positive management actions to give it intermediate sanction authority. Currently, other than terminating a contract with an HMO, there are no intermediate level sanctions to provide incentives for an HMO to abide by its contract provisions. We agree that these are necessary first steps toward resolving this problem.

In regard to our second recommendation, HHS stated that HCFA has developed a timeliness-of-payment standard to be included in all Medicare HMO/CMP contracts to help avoid the types of problems we found with IMC's timeliness of provider payments. The standard, still being finalized on June 19, 1986, when we last discussed it with HCFA, parallels the payment standard that HCFA applies to its intermediaries and carriers. HCFA intends to include the standard in all new contracts as well as those that renew on or after July 1, 1986. The IMC contract comes up for renewal on January 1, 1987.

In an overall comment, HHS stated that the report's presentation appears to mix pre- and post-TEFRA oversight and activities of the HMOs. The TEFRA regulations were effective February 1985, and the four Florida demonstration projects became subject to these regulations in April 1985. We believe the report makes clear (1) the timing relative to TEFRA

regulations of the oversight problems and activities of the HMOs it discusses and (2) the persistence of a number of significant problems after issuance of the regulations.

While we would agree that waiving the 50-50 composition-of-enrollment requirement for a new TEFRA HMO is not likely to occur very often in the future, the concerns created by waiving this provision for IMC were recognized prior to the TEFRA regulations and persist now (June 1986). Furthermore, other unresolved issues cited in this and other chapters of the report were acknowledged to exist prior to issuance of TEFRA regulations and were not resolved as of June 1986. These involve (1) timeliness of HMO provider payments, (2) an HMO organizational model that dilutes PHS and/Medicare Act/beneficiary safeguards, (3) potential screening of pre-HMO enrollees for health status, (4) the absence of a PRO review function for Medicare HMO enrollees, and (5) HMOs' noncompliance with the grievance and Medicare appeals processes available to HMO enrollees.

HMO Network-Type Structure Limits Effects of Legislated Safeguards

Risk-based HMOs are capitated—paid a fixed amount per month per enrollee to provide all primary care to the enrollees. To the extent that such an HMO does not manage its members' use of medical services effectively, does not enroll enough members over which to spread its risks, or lacks the financial resources to provide for unanticipated high utilization, its financial viability is threatened. Consequently, capitation gives HMOs strong incentives to control utilization.

Should a risk-based HMO's financial viability decrease, its incentives to reduce quality of care may grow. Therefore, the PHS and Medicare Acts and regulations provide certain safeguards to protect HMO members and to minimize the potential for financial insolvency and decreased quality of care. Each risk-based HMO participating in Medicare must have a fiscally sound operation and a plan for handling insolvency, enroll enough members to help spread its risk, and ordinarily hold its number of Medicare and Medicaid enrollees to no more than half its total membership.

But the degree to which these safeguards are effective depends to some extent on the structure or model of the HMO. As we discuss in this chapter, the network HMO passes on much of the risks of its enrollees' health care costs to affiliated providers that may have relatively small memberships and/or predominately Medicare memberships; these affiliates are not required to comply with the PHS/Medicare requirements. Because the HMO program is expanding rapidly and new HMOs may adopt the network-type model, it is important to address this issue now and take actions to ensure that statutory safeguards have their intended effect.

One of the four Florida HMOs we reviewed, IMC, operated a service delivery network that significantly limited the effects of the federal safeguards, and another, CAC, was beginning to operate in such a manner.

HMO Contractual Arrangements With Providers Vary

There are four organizational models through which HMOs provide physicians' services to enrollees:

1. Staff HMOs provide services at one or more locations through primary care physicians who are HMO salaried employees;

2. Group practice HMOs contract with a group of physicians who provide care at one or more sites;

3. Individual practice association (IPA) HMOs contract with physicians in the community who practice out of their own offices and see HMO members there; and

4. Network HMOs contract with more than one medical group or IPA organization, each offering a full range of comprehensive benefits.

Of the four HMOs we examined, AV-MED was an IPA; HealthAmerica was a staff model; and IMC and CAC were combined staff and network models.

Under AV-MED's IPA model, HMO enrollees received physician services from participating primary care physicians under contract with AV-MED Associates, an IPA. Typically, AV-MED's primary care physicians were capitated. AV-MED also contracted with specialist physicians to whom the primary care physicians could refer enrollees and whom it paid on a fee-for-service basis.

Under the staff model operated by HealthAmerica and the staff model components operated by IMC and CAC, physicians were salaried employees of the HMOs and provided services to enrollees at the HMOs' clinics. As with the IPA model, these HMOs also contracted with specialists to whom the HMOs' physician-employees referred enrollees on either a fee-for-service or capitated basis.

IMC and CAC both operated networks in addition to their staff arrangements. A distinguishing characteristic of the network model under IMC and CAC was that a greater part of the HMO's risks for cost of care was transferred to its participating physician groups than under either the IPA or staff models we reviewed. Under these network arrangements, the participating physicians' groups were capitated, not only for the care they personally provided enrollees, but also for referrals to specialists and a portion of enrollees' institutional care, such as hospitalizations. The details of the two network models are as follows:

- IMC contracted, as of August 1, 1985, with 103 affiliated provider groups,[1] which operated 157 health centers and provided services to 116,270 (65.6 percent) of IMC's Medicare and non-Medicare members. These groups were owned and operated by private entities that agreed to provide services to IMC members and were paid by IMC on a capitated basis. Depending on the group's geographic location, IMC kept various

[1]If an affiliated provider owned more than one health center, we counted all the centers owned by that provider as one affiliated provider group

percentages of the payment it received from HCFA to cover its administrative and other costs and paid the remainder to the groups to cover their patient care and associated administrative costs. From this capitation payment, the groups paid for all physician and specialist services and institutional care. For institutional care, however, they shared 50 percent of any profit earned or loss incurred with IMC based on the difference between the capitation paid by IMC and the group's costs.

- CAC contracted, as of November 1, 1985, with 28 affiliated providers to provide services to its members. CAC paid these groups on a capitated basis; it kept a percentage of its HCFA payment to cover administrative and other costs and paid the remainder to the groups. As with IMC, these providers paid for all physician and specialist services and institutional care, but shared 55 percent of any profit earned or loss incurred on institutional care with CAC.

Because transferring risk from HMOs to affiliated groups results in entities that function in many respects as independent HMOs with little or no federal or state oversight, we devote the remainder of this chapter to the network model. We focus on IMC because CAC was only beginning to develop a network structure during our review. Literature on HMOs' organizational structures indicate there are other network HMOs in HCFA's demonstration program, but HCFA could provide few details that would enable us to determine whether these other HMO networks were similar to IMC and CAC.

Key Legislative Safeguards Not Applicable to HMO Affiliates

The PHS Act requires federally qualified HMOs to adhere to financial solvency requirements, and the Medicare law contains membership enrollment standards to safeguard against both insolvency and reductions in quality of care. Each federally qualified HMO participating in the Medicare program must

- have a fiscally sound operation and a plan for handling insolvency to protect members against the risks of the HMO becoming bankrupt (section 1301 of the PHS Act);
- enroll at least 5,000 members,[2] according to its Medicare risk contract (section 1876 of the Social Security Act); and
- limit the number of Medicare and Medicaid enrollees to 50 percent of its total membership to help assure quality of care (unless HCFA grants a waiver or exception, as it did to IMC) (section 1876 of the Social Security Act).

[2]Rural HMOs must have 1,500 members

These safeguards have not, however, been applied to HMOs' affiliated providers. The PHS Act authorized the HHS Secretary to require contracts between an HMO and its providers to include provisions related to sound fiscal management and quality of care. But HHS regulations include no such requirements, other than that providers must have professional liability coverage and participate in quality assurance activities as part of the federal qualification and compliance process for HMOs

When applying for federal qualification or an expansion of its federally qualified service area, an HMO must give OHMO financial information that includes its financial statements and an insolvency plan. But, except for information on affiliated providers' malpractice insurance, the HMO need not include information on the financial condition of its affiliates.

IMC's request to OHMO to expand its service area to Broward and Palm Beach counties and the Tampa Bay area was approved in March 1985 (as discussed on p 34). The final qualification report on IMC from OHMO's Qualification Division included the following statements:

"IMC has transferred extensive risks to small affiliated provider groups who may not have the financial resources nor medical management capability to bear the risk There is evidence that a number of provider groups may be forced to drop out of IMC because of financial losses

"Problems with the affiliated providers have been identified in the qualification review that indicate that the delegated system is not working appropriately in a significant number of cases Of most critical concern is the fact that three out of the six provider groups we visited were experiencing severe losses on the IMC capitation and there were reports that other providers are having similar financial problems

" . Therefore, it is recommended that an assurance be added to the qualification approval letter which will require IMC management to devote immediate attention to this issue and report back to OHMO in sixty days on the financial status of the affiliated groups and steps that have been taken to strengthen IMC's management and monitoring of the delivery system."

OHMO did not, however, include the recommended assurance in its March 25, 1985, qualification approval letter to IMC. According to OHMO officials, this was because OHMO believed it had no specific authority to require this as a condition for approving IMC's application for expansion as a federally qualified HMO. OHMO took this position because current PHS regulations do not require that an HMO provide them with information on its subcontractors' financial condition. However, section 1301(b)(3)(D) of the PHS Act provides that

"Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management."

While current PHS regulations do not require these contracts to include any such provisions, Medicaid regulations (which also apply to HMO contracts) do. Medicaid requires all subcontracts to fulfill the general Medicaid contracting requirements appropriate to the service delegated under the subcontract. So in this regard, Medicaid's regulations are more stringent than Medicare's.

After becoming federally qualified, HMOs must submit quarterly or annual financial reports to OHMO—the only routine financial information it receives about them, according to OHMO Compliance Division officials. But, because these reports include no financial data about affiliated providers, OHMO has no routine information on them.

Florida state law and regulations also address only the financial condition of the HMO itself—not its affiliated providers. In Florida, each HMO must submit an annual report to the Department of Insurance, which examines the financial affairs of each HMO at least every 3 years. Florida's required annual report on IMC did not cover its affiliates' finances, nor did the latest reviews of IMC, done in September 1983 and December 1984.

IMC Affiliates' Finances, Enrollment Compared With HMO Safeguards

At IMC, the only HMO we reviewed that had a fully operational network model in place, IMC management classified many of the affiliated providers as needing financial improvement. This raises the question of whether they would be able to independently meet the financial solvency requirements established for HMOs. Additionally, few of the affiliates met the membership requirements established for HMOs. In brief, the status of IMC affiliates was as follows:

- Financial condition. Of the 48 affiliated provider groups IMC had reviewed as of July 15, 1985, it considered the financial condition of 16 (serving 21,196 Medicare members or about 24 percent of IMC's Medicare enrollment served by affiliated providers) as needing improvement. IMC could not determine the financial status of 5 (serving 14,624 Medicare members or about 17 percent of IMC's Medicare membership served by

the affiliated providers) because it was refused access to necessary records.

- Membership. Of IMC's 103 affiliated provider groups (serving 88,635 Medicare members, or nearly 72 percent of its Medicare membership), only 3 had total memberships of 5,000 or more persons as of August 1, 1985.
- Enrollment mix. Only 9 of the 103 provider groups met the 50-50 Medicare/Medicaid enrollment mix standard as of August 1, 1985.

More details on these aspects of IMC's operations follow.

Financial Status of Affiliates

OHMO and the state of Florida knew little about the financial condition of the affiliated providers of IMC. Recognizing that lack of information on the financial condition of these providers could develop into problems for IMC and its members, the HMO in January 1985 formed a field audit group to review its affiliates' financial viability. This review was done under provisions of IMC's contracts with the affiliates that gave it access to their records.

As of July 15, 1985, IMC had reviewed 48 affiliated groups, which served 81 percent of its Medicare members served by affiliated providers. Of the 48 providers, the financial condition of 27 was termed by IMC management as "satisfactory," 16 as "needing improvement," and 5 did not provide information needed by IMC to make a determination (see table 3.1).

Table 3.1: Financial Condition of IMC Affiliated Groups: Results of IMC Audit

Financial condition	No. of groups	No. of Medicare members	Percent of IMC's Medicare members served by affiliates
Needed improvement	16	21,196	23 9
Satisfactory	27	36,340	41 0
No information provided	5	14,624	16 5

IMC's reviews lacked enough detailed information for us to determine whether the 48 affiliated providers would have complied with federal or state HMO financial solvency standards. In addition, as about 21 providers were not using the accrual basis of accounting, the IMC auditors noted, the possibility of unrecorded liabilities would not be disclosed.

Besides auditing affiliated provider groups then under contract, IMC began financially screening potential affiliates in the spring of 1985. The screening process generally involved assessing the providers' financial sophistication and availability of resources to sustain operations over a 6-month period.

As required by federal regulations, IMC had a plan to handle its own insolvency. Also, IMC contractually required that affiliated providers (1) provide services as required by federal regulations if IMC became insolvent and (2) not bill enrollees for services that IMC had to pay for. (IMC had insurance to cover claims if it became insolvent, but the insurance did not cover claims incurred by an affiliated provider that became insolvent. According to IMC officials, any losses related to an affiliated provider's insolvency would have to be covered by IMC.)

One of IMC's affiliated providers filed for bankruptcy in the spring of 1985. IMC was unaware of the extent of this provider's financial difficulties until the filing. In April 1985, IMC estimated the provider owed $900,000 to doctors and pharmacies, although IMC originally had thought a $150,000 loan would be sufficient to resolve the problems. When the affiliate filed for bankruptcy, it actually owed $1,092,000 to 428 providers (e.g., doctors, pharmacists). After negotiating with several of these providers to pay them a specific percentage of their bills, IMC agreed to pay them $873,000. As of November 1, 1985, IMC had paid $759,000 of this amount and was processing the balance.

Of the 16 affiliated providers whose financial conditions IMC management termed as "needing improvement," none of the problems appeared to approach the magnitude of the bankrupt affiliate, according to our analysis of the audits. For example:

- During an 11-month period (February 1-December 1, 1984), one provider had a net income of $43,331 but a negative net worth of $37,820. As of March 1, 1985, the provider had about $71,700 in unpaid invoices and, during the first 3 months of 1985, lost $3,331.
- Another provider had a net income of $6,315 for the month of March 1985 but a negative net worth of $4,368. IMC's auditors noted that the provider's income-generating potential did not appear strong and the long-term debt at $75,000 was high.

Number of Enrollees in IMC Affiliates

As a network HMO parcels out its enrollees to affiliates and transfers the risks of patient care costs to them, the potential exists that an affiliate may have an enrollment base so low that it may not be able to consistently function profitably and also provide quality care. While we do not know at what level of enrollment this would happen, some level certainly exists.

A subsidiary whose parent corporation meets eligibility requirements for a risk contract need not meet the 5,000-member requirement on its own, as long as the parent corporation assumes responsibility for the financial risk of health care services the subsidiary provides. This is stated in the regulations implementing section 1876 of the Social Security Act, as amended by TEFRA. IMC's affiliated providers are not, however, subsidiaries of the HMO, and their contracts with IMC do not transfer responsibility for the risk of losses back to IMC in the event of their insolvency. Nevertheless, under federal regulations and IMC's contracts with the affiliated providers, the beneficiaries cannot be held liable for services for which the affiliated providers or IMC are financially liable.

Of IMC's 103 affiliated providers, 100 had less than 5,000 members (see table 3.2); had they been HMOs, they would not have met the total enrollment requirement. These 100 affiliated providers provided services to 69,161 Medicare members or about 56 percent of IMC's Medicare membership. Therefore, more than one-half of IMC's Medicare members received services from an affiliated provider that, were it an HMO, would not meet the federal enrollment requirement.

Table 3.2: Enrollment of IMC Affiliated Providers (August 1, 1985)

Range of enrollment	No. of affiliates
5,000 or more	3
Subtotal	**3**
4,000 - 4,999	2
3,000 - 3,999	4
2,000 - 2,999	8
1,000 - 1,999	16
Less than 1,000	70
Subtotal	**100**
Total	**103**

Enrollment Mix of IMC Affiliates

IMC was granted a 3-year exception from Medicare's standard that no more than 50 percent of an HMO's membership be Medicare and Medicaid enrollees (as we discuss on p. 29). In December 1985, IMC's projected membership was about 67 percent Medicare (see table 2.3). Most of them (67 percent) were being served by affiliated providers, few of which would meet the 50-50 enrollment standard if treated as independent HMOs. As of August 1, 1985, 94 of IMC's 103 affiliated providers had not met the 50-percent standard, as table 3.3 shows. These 94 affiliates provided services to 85,315 Medicare members.

Table 3.3: Enrollment of Medicare and Medicaid Beneficiaries in IMC Affiliates (August 1, 1985)

Percent of affiliates' Medicare and Medicaid-eligible membership	No. of affiliated providers
50 and less	9
50 1 - 65	14
65 1 - 75	12
75 1 - 85	23
85 1 - 95	18
95 1 - 100	27
Total	**103**

IMC's overall compliance with the 50-50 standard needs to be addressed. But even if IMC were to achieve system-wide compliance, there is no assurance that the risk-bearing affiliated providers would meet the standard. Although we are not suggesting that every component of an HMO such as IMC should meet this standard, the Congress in establishing it intended to preclude the development of Medicare-only HMOs, and some standard appears appropriate. This raises two questions: When are risk-bearing affiliates considered HMOs, and with what standards should they be required to comply?

Conclusions

During its qualification review of IMC, OHMO expressed concerns about the ability of small affiliated provider groups to bear the financial risks associated with the HMO's network approach. At the time, OHMO believed it lacked specific authority to require data on the financial status of the affiliates as a condition for IMC qualification. But the emergence of network-type HMOs, which feature a large number of small affiliated providers at substantial risk, requires appropriate modifications to the process to cover the financial viability of these risk-bearing affiliates as well.

In addition, IMC has, by initiating financial audits of its risk-bearing affiliates and screening potential new affiliates before entering into a contract, evidenced its concerns relating to the financial viability of these entities and the potential impact of affiliates' insolvency on IMC's own operations.

The concerns expressed by OHMO during its qualification review of IMC and evidenced by IMC were valid and also raised a larger question. How much risk transference from the HMO to an affiliate is necessary before the affiliate should itself be considered an HMO, subject to the full range of federal requirements and standards applied to the HMO itself? This is important, because at present, HMO risk-bearing affiliates receive little federal or state oversight, even though in Florida, at least, they serve large numbers of Medicare enrollees.

We believe the risk IMC transferred to its affiliates was substantial. Furthermore, under these conditions, HHS should play a role in protecting both Medicare and non-Medicare members. Specifically, we believe HHS should require HMOs to include and enforce contract provisions with their affiliates to help assure their sound fiscal management and ability to deliver quality health care services. HHS, in our opinion, already has the authority under section 1301(b)(3)(D) of the PHS Act to require appropriate financial reports on the condition of affiliates, but it has not issued regulations to do so. We believe that HHS should issue such regulations.

Collecting financial information on risk-bearing affiliates seems to us an imperative for HMOs and HHS. In addition, HHS also needs to decide when it is necessary, because of the risk assumed by affiliates, to require that an HMO's contracts with affiliates provide that they meet the 5,000-enrollee and Medicare/Medicaid mix standards imposed on the HMO itself.

Recommendation to the Secretary of HHS

We recommend that the Secretary issue regulations specifying standards for financial solvency and enrollment that an HMO must require of those subcontractors, such as IMC's affiliated providers, that bear substantial risk, particularly for services provided by others. At a minimum, the Secretary should require that an HMO contract with such risk-bearing affiliates provide the HMO with annual audited financial statements for its use in managing the affiliates and assessing its own financial condition. Furthermore, these data should be made available to HHS upon its

request for use in making qualification and compliance determinations related to the financial status of the HMO and its affiliates.

Agency Comments and Our Evaluation

HHS took no clear position relative to our recommendation. The Department stated that HMOs must assume full financial risk for providing services to Medicare enrollees, and are not free to transfer the risk of losses without entering an agreement with HCFA. But it did not address the fundamental issue of what role the agency should play in protecting Medicare members of HMOs that deliver many of their services through subcontractors bearing substantial risks. As we discussed in the report, these subcontractors operate much like HMOs but are not subject to Medicare's HMO financial viability and quality standards and receive little federal or state oversight.

HHS agrees that where a substantial portion of Medicare enrollees are served through risk-bearing contracts, such contractors' performance significantly affects the availability, accessibility, and quality of care provided to Medicare beneficiaries. However, HHS does not say what it plans to do to implement safeguards to help assure the availability, accessibility, and quality of care provided by such contractors.

The Department did comment that our use of the term "risk-bearing subcontractor" is too broad and needs to be defined. The agency is concerned that too broad a definition would include physicians, home health agencies, and other small health care providers and that to require each of these small subcontractors to meet financial solvency standards would impose a significant burden to network model HMOs and would not be effective. Our recommendation refers to subcontractors, such as IMC's affiliated providers, that bear risk not only for the services of their physicians but also for referrals to specialists and for a portion of hospital care. We have clarified our recommendation to be more explicit in this regard.

Medicare HMO Payment Rates Found to Be Excessive If Anticipated Savings Are to Be Achieved

When the Congress passed TEFRA, it amended the Social Security Act[1] to modify requirements for Medicare "risk-sharing contracts" with HMOs. In return for providing specified health care services to Medicare enrollees, the organization would receive a fixed predetermined payment. The payment to the HMO for each Medicare enrollee would equal 95 percent of the adjusted average per capita cost for the enrollee's county of residence and the demographic class to which that enrollee was assigned.[2] This arrangement was expected to save the Medicare program 5 percent.

For these savings to occur, however, the HMO's membership would have to be broadly representative of the general Medicare population in terms of health status or the health status of enrollees would have to be considered in setting payment rates. Deviation from the Medicare population could arise from independent enrollment/disenrollment decisions by Medicare beneficiaries or from certain practices by HMOs. For instance, HMOs have a financial incentive to enroll healthy individuals and to "screen out"[3] and dissuade from enrolling those who are very ill (or, if the latter are already enrolled, to encourage their disenrollment). There are, however, prohibitions against such practices.

HCFA does not use the health status of Medicare beneficiaries who enroll with risk-contract HMOs when setting capitation payments to the HMOs because it has not identified an acceptable methodology for doing so (it is, however, studying the issue). Consequently, for some enrollees Medicare pays too much and for others too little. Such a situation is typical in any prepayment system; it is of concern only if, on average across all enrollees, the high and low payments do not balance out. Medicare pays HMOs a price which assumes that an average group (adjusted for age, sex, and institutional and Medicaid status) of Medicare beneficiaries in a given county will enroll and stay enrolled.

[1]Section 1876, as amended by section 114 of TEFRA

[2]The financial requirements imposed on the risk organization through the adjusted community rate (ACR), which reflects rates charged by the organization to non-Medicare enrollees, are discussed on pages 72-74.

[3]Screening refers to the use of information on the relative health status of those applying for HMO membership as a means of not enrolling those requiring high levels of medical care

But on average, those enrolled in the HMOs we studied were a "healthier"[4] group of Medicare beneficiaries. The 27 HMOs with risk contracts in 1984 that we analyzed lacked on average a representative mix of enrollees, as measured by mortality rates. The Medicare beneficiaries in these HMOs were experiencing about 77 percent of actuarially projected mortality, adjusted for the age, sex, institutional status, and Medicaid eligibility of HMO enrollees. This indicated a significantly healthier enrollment than would be representative of a random selection of all Medicare beneficiaries (adjusted for the same factors). The net result of this mix of HMO enrollees was either excessive earnings for the HMO or a more comprehensive benefit package for HMO enrollees.

To assess whether HMO disenrollees were higher or lower users of Medicare services, we analyzed their use of part A services during the 3-month period immediately following disenrollment. Disenrollees from these 27 HMOs used part A services at approximately the same rate after disenrollment as the Medicare average. But reimbursement for such service following disenrollment was about 50 percent less than the part A portion of the AAPCC payment that would have been made had disenrollment not occurred. While this might suggest that the AAPCC is too high, it is based only on disenrollees, who may not be representative of those remaining in the HMOs. In itself, we believe, this difference does not support a conclusion that the AAPCC is excessive.

The potential for screening existed, judging from the allegations we obtained from Florida Blue Cross/Blue Shield and OHMO and our analysis of part B services provided to HMO enrollees 1 month before they enrolled. Consequently, we reviewed the four HMOs' top five providers of services to preenrollees and found that about 41 percent of CAC's new enrollees had been seen by CAC physicians in the month immediately preceding their effective dates of enrollment. Also, two IMC affiliates had generated significant revenues for services provided to new IMC enrollees in the month preceding their effective enrollment dates. But, although the four HMOs were aware of new enrollees' health status prior to their effective enrollment dates in a sample we examined, we cannot conclude that the HMOs used these data to avoid enrolling less healthy applicants, because our analysis of part B services was limited to individuals that actually enrolled.

[4]We use the term "healthier" because of our finding that HMO enrollees were experiencing lower mortality rates than expected The term is used because of the high association between mortality and morbidity (illness) as indicated by Medicare health expenditures for beneficiaries during their last year of life

HCFA's payment to the risk-based HMOs includes about 1.3 percent added to the capitation rate for administrative costs. We believe that this will result in an overall increase in Medicare's administrative costs above that which would occur if HMO enrollees remained in or returned to regular Medicare. HCFA bases the payment on average rather than marginal or incremental costs, which would more accurately reflect the administrative costs it would incur if a group of HMO enrollees returned to regular Medicare. Also, although carriers and intermediaries still perform certain administrative tasks relating to the HMOs, their costs to Medicare are not considered in computing the add-on.

Payments Based on Costs, Demographics

According to section 1876, the payment level for each aged or disabled Medicare enrollee in a risk-based HMO must equal 95 percent of the AAPCC for the enrollee's county of residence and demographic class. The methodology employed to set rates must assure actuarial equivalence—i.e., payments to HMOs must be 95 percent of the payments Medicare would have made had their members obtained their medical services from the fee-for-service sector. Also, the payment rates vary by geographic location.

To calculate the AAPCC payment rates, HCFA does the following:

1. Projects the national average per capita Medicare costs to the payment year being developed.

2. Projects 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-enrollee costs. Thus, geographic areas that experienced low average per-enrollee reimbursement in the fee-for-service sector during the 5-year interval included in the average will receive low HMO payments. In contrast, geographic areas with historically high per-enrollee reimbursement in the fee-for-service sector would receive high HMO payments.

3. Using demographic adjustment factors, county per capita costs (with the per capita cost of prepaid health plans removed) are converted into rates. Data from the Current Medicare Survey[5] for 1974-76, including approximately 20,000 Medicare beneficiary-years of observations, are

[5]A 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

used to calculate the demographic adjustment factors (as described below) for parts A and B. HCFA then calculates separate rates for the Medicare aged, disabled, and ESRD beneficiaries.

This methodology is described fully in a Federal Register notice of January 6, 1986.

Enrollees are assigned to demographic classes based on their Medicare entitlement status (aged, disabled, or ESRD), geographic location, age, sex, institutionalization, and Medicaid status. For each demographic class, HCFA estimates what it would cost to provide Medicare services to that class of beneficiary in the fee-for-service sector. Estimates for the parts A and B AAPCCs are made separately for the aged and disabled by county (or state, for individuals with ESRD).

The demographic categories include male and female, subdivided into five age groups. Further, the institutionalization and Medicaid status indicators are used to assign a given enrollee to 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). The rates established by HCFA for these 30 cells for Dade County, Florida, are listed in table 4.1.

Table 4.1: Medicare Monthly Payment Rates to HMOs for Dade County, by Demographic Class for the Aged (1986)[a]

	Male			Female		
		Noninstitutionalized			Noninstitutionalized	
Age group	Institutionalized	Medicaid	Non-Medicaid	Institutionalized	Medicaid	Non-Medicaid
65-69	$626 92	$426 70	$256 50	$538 55	$324 17	$216 11
70-74	736.02	531.99	307 25	610 01	395.63	256 50
75-79	736 02	634 52	372 15	630 72	447 41	300 69
80-84	736 02	696 66	392 87	630 72	499 19	331 76
+84	736 02	696 66	392 87	630 72	550 98	352 47

[a]Parts A and B combined

The rate shown for each of the cell entries is 95 percent of the AAPCC value. Payment levels across the demographic factors vary substantially. The highest payment, $736.02, is for an institutionalized male, aged 70 and over; the lowest is $216.11 for a female, aged 65 to 69, noninstitutionalized and non-Medicaid.

There is also considerable geographic variation in payment levels. To illustrate this, we chose one demographic cell (male, aged 75 to 79,

noninstitutionalized, and non-Medicaid). We calculated the parts A and B combined payment levels both for six Florida counties where risk HMOs were in operation in 1985 and for Jefferson County, which, of all of the Florida counties, would have the lowest payment levels if a risk HMO were in operation there. As table 4.2 shows, the 1986 payment levels would vary by a factor of nearly three and one-half, from $108.85 for Jefferson County to $372.15 for Dade County.

Table 4.2: Comparison of AAPCC Payment Levels Across Seven Florida Counties

Florida county	AAPCC Medicare payment[a]
No risk HMO in operation	
Jefferson	$108 85[b]
Risk HMOs in operation	
Pasco	193 16
Hillsborough	216 06
Pinellas	223 32
Palm Beach	225 46
Broward	302 86
Dade	372 15

[a]1986 AAPCC parts A and B HMO combined payment levels for a male aged 75 to 79, noninstitutionalized and non-Medicaid

[b]Level of Medicare payments if a risk HMO were in operation

Excessive Payment Rates Result of Fewer High Cost Enrollees

Mortality rates for Medicare beneficiaries in the 27 risk-based demonstration HMOs were lower than would be actuarially expected based on our calculations. This indicates, we believe, that such enrollees are healthier, the HMOs' costs for them should be lower than HCFA predicted, and the AAPCC payment rate is excessive. Contributing to this imbalance is the fact that the last year of a beneficiary's life is his or her most costly (on average) to Medicare.

The Congress was aware that the AAPCC payment methodology might inappropriately compensate risk HMOs. It required that, before TEFRA HMO provisions could be implemented, HHS notify three Congressional committees that it was reasonably certain that the methodology to make appropriate adjustments (referred to in section 1876(a)(4) of the Social Security Act, as amended by TEFRA) had been developed and could be implemented to assure actuarial equivalence in the AAPCC estimation.

On January 7, 1985, the Secretary advised the three committees that she was reasonably certain that the methodology met these requirements.

During the period between the enactment of TEFRA and January 7, 1985, HCFA implemented some improvements in data sources used to compute the AAPCC payment levels but made no adjustments to the methodology, except for a technical change in the calculation of county per capita costs.

To determine how much to pay risk HMOs, Medicare must estimate how much it would cost in the fee-for-service sector to provide Medicare services to a given group of beneficiaries that actually enrolls in a particular HMO. HCFA cannot determine this directly because HMO enrollees in fact are not in the fee-for-service sector.

Consequently, to assess the reasonableness of AAPCC rates, we had to rely on an indirect measure. For the 27 pre-TEFRA risk-based HMOs included in our analysis, we compared actual and actuarially predicted mortality rates, adjusted for age, sex, institutional and Medicaid status, and the length of time individuals were enrolled during calendar year 1984. We found that the mortality rates for HMO members were about 23 percent lower than would be actuarially predicted when adjusted for HMOs' enrollment of institutionalized and Medicaid beneficiaries. This indicated that healthier individuals were enrolled in HMOs than in Medicare generally.

Large Share of Costs Incurred by Relatively Few Beneficiaries

The higher costs to Medicare of treating beneficiaries in their last year of life may be one reason there is a skewed distribution of Medicare reimbursements. According to the latest available HCFA statistics, in 1983, over 72 percent of all Medicare reimbursements for the aged went for services to 9.6 percent of the aged enrollees, as table 4.3 shows. Of the remaining 90.4 percent of aged beneficiaries, 37.4 percent had no reimbursement at all.

Table 4.3: Distribution of Medicare Enrollment and Reimbursement for the Aged by Reimbursement Category (1983)

Type of coverage and reimbursement interval	Beneficiaries		Reimbursement	
	No. in thousands	Percent distribution	Amount in millions	Percent distribution
All beneficiaries enrolled in parts A and B	28,610	100 0	$46,727	100 0
Beneficiaries with no reimbursement	10,713	37.4	•	•
Beneficiaries with reimbursement	17,897	62 6	46,727	100 0
Reimbursement interval				
Less than $1,000	11,115	38 9	2,689	5 8
$1,000-$1,999	1,577	5 5	2,302	4 9
$2,000-$4,999	2,460	8 6	8,016	17 2
$5,000 or more	2,746	9 6	33,720	72 1

Source HCFA, Bureau of Data Management and Strategy

According to a HCFA study of aged beneficiaries, 67 years and older, it cost Medicare 6.2 times as much to provide services to 1978 decedents in their last year of life as it cost to provide services to the surviving beneficiaries (see table 4.4). The average reimbursement was $4,527 for decedents compared to $729 for survivors. According to this study, published in 1984, approximately 28 percent of all Medicare reimbursements were for services provided to the 5.9 percent of Medicare beneficiaries in their last year of life.

Given that a relatively small percentage of the aged account for most of the Medicare reimbursement, an HMO would have to avoid enrolling proportionately few aged individuals to significantly improve its profitability. And to the extent that this small, high-cost group of Medicare beneficiaries is not enrolling in or remaining in a risk HMO, either on their own initiative or because of actions by the HMO, AAPCC rates are inappropriately high.

Table 4.4: Medicare Reimbursement for 1978 Decedents in Their Last Year of Life and Survivors in 1978, by Age

Age	Decedents in last year of life	Survivors	Decedent-to-survivor reimbursement ratio
67 years and older	$4,527	$729	6 2
67-69 years	5,801	592	9 8
70-74 years	5,466	668	8 2
75-79 years	5,056	771	6 5
80-84 years	4,274	859	5 0
85 years and older	3,285	889	3 7

Source J Lubitz and R Prihoda, "The Use and Costs of Medicare Services in the Last 2 Years of Life," Health Care Financing Review, Vol 5, No 3, 1984, pp 117-131

HMO Mortality Rates Lower Than Projected

Among enrollees in the 27 demonstration HMOs during 1984, the mortality rate was 66 percent of the age and sex-adjusted actuarially projected level (as discussed later, institutional and Medicaid adjustments will increase this percentage to 77). Thus, in our opinion, these HMOs may have been paid for services they did not have to provide because their enrollees were healthier than average, considering the disproportionately high cost of providing services to beneficiaries in the last year of life. Given the age and sex composition of those enrolled in the 27 demonstration HMOs in 1984, the projected mortality was 7,984 (see table 4.5). The actual mortality for these HMOs was 5,236—66 percent of

Table 4.5: Actual and Expected Mortality in Risk HMOs (1984)

HMO	Mortality rates		
	Actual	Actuarially projected	Actual as percent of projected
AV-MED	258	338	76
HealthAmerica	69	97	71
IMC	2,348	3,623	65
CAC	67	142	47
All 27 risk HMOs	5,236	7,984	66[a]

[a]Represents a weighted average

that projected.[6] For all HMOs combined, projected mortality rates were greater than actual rates for all age categories, as figure 4.1 illustrates.

But the risk-based HMOs had a lower proportion of Medicaid-eligible enrollees than did the overall Medicare population (3.6 versus 9.9 percent) and a lower proportion of institutionalized enrollees (0.2 versus 4.8 percent). Each of these under-represented groups had high mortality rates. Compared to all aged Medicare beneficiaries, the institutionalized mortality was approximately six times higher. For the Medicaid eligibles, mortality was 1.5 times higher than for the non-Medicaid eligible Medicare beneficiaries (see app. I). The combined effect of the lower-than-proportionate HMO enrollment of the institutionalized and Medicaid eligibles was to increase the ratio of actual to expected mortality from approximately the 66 percent ratio discussed above to approximately 77 percent, as appendix I also shows.

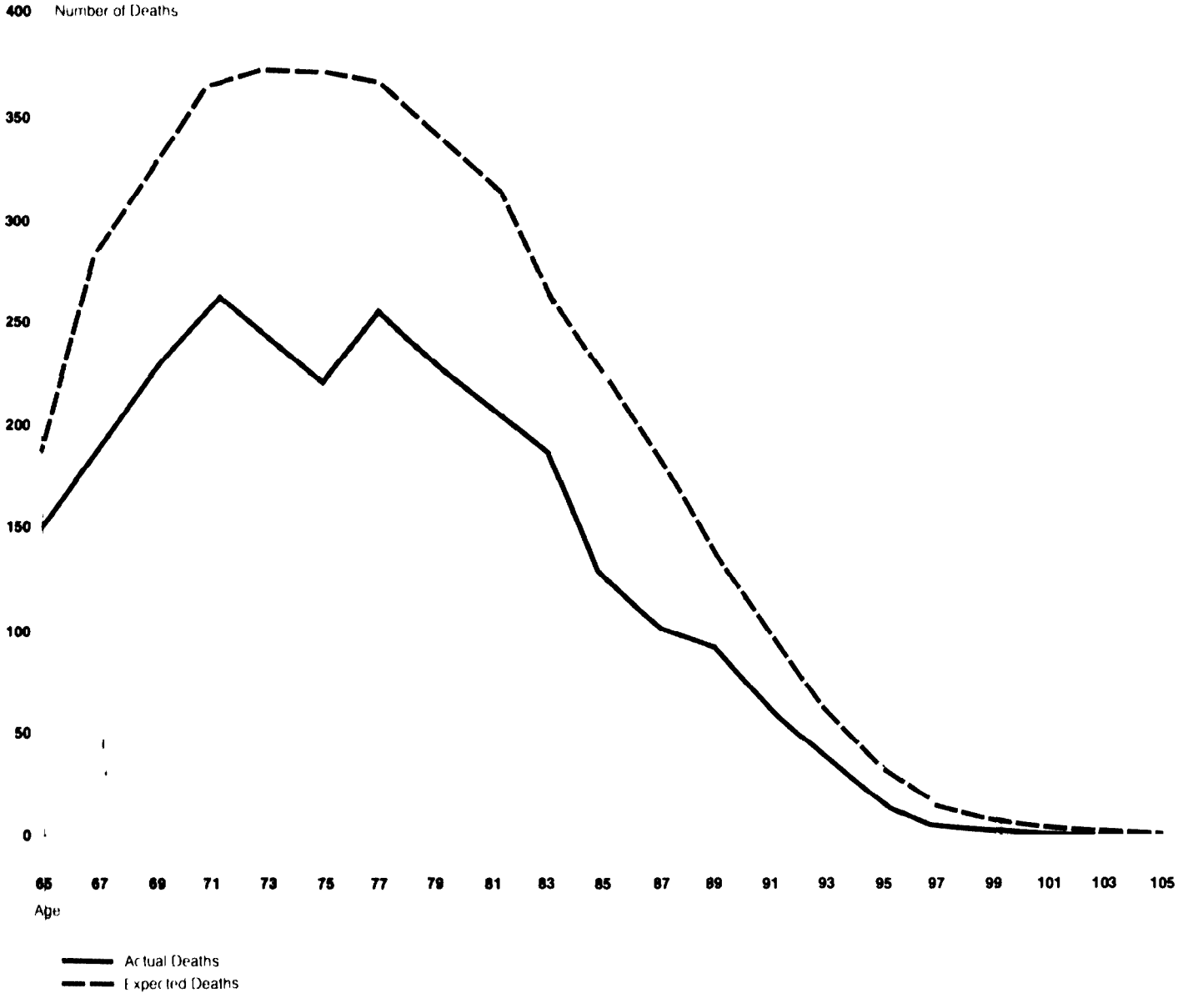
Risk HMOs may be experiencing lower than expected mortality for several reasons:

1. A disproportionate number of beneficiaries who have been high users of Medicare services and thus perhaps less healthy than average may have elected not to join HMOs. For example, data for two out of three HMOs examined by HCFA researchers indicated that HMO Medicare enrollees tended to be among those who used a relatively lower amount of Medicare-covered services prior to enrollment.[7] In the 4 years prior to HMO enrollment, enrollees in two HMOs had 20-percent lower Medicare reimbursements than did their respective comparison groups. In the third HMO, there was no statistically significant difference between the HMO enrollees and a comparison group. From these data, the authors of

[6]Three HMOs in Minnesota (Share Health Plan, MedCenters Health Plan, and HMO Minnesota) were allowed to screen applicants for high option plans on the basis of their health status as a part of the demonstration experiment If these HMOs were excluded, the ratio of actual to expected mortality would rise to 67 percent

[7]P Eggers and R Prihoda, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in At-Risk HMOs," Health Care Financing Review, Vol 4, No 1, September 1982, pp 55-73

Figure 4.1: Actual Versus Expected Deaths of Enrollees in All 27 Risk HMOs, by Age (1984)



the research concluded that ". . . the AAPCC methodology may not be an adequate mechanism for setting HMO prospective reimbursement rates."

2. The HMOs' emphasis on preventive care, it has been argued, also may improve members' overall health and thereby contribute to lower mortality rates. We did not attempt to quantify this because, in the south Florida HMOs we reviewed, most Medicare members had not been enrolled long enough, in our judgment, to reasonably expect this to have a significant effect.

HMO Participation Unlikely to Decrease Medicare Outlays

Under the present method of reimbursing HMOs at 95 percent of the AAPCC, we believe the HMO program is unlikely to result in overall Medicare program savings, given that the 27 risk-based HMOs analyzed had a membership composed of a relatively higher proportion of lower cost Medicare beneficiaries, as measured by their lower mortality rates. Consequently, to achieve the savings expected, payment rates would have to be reduced. Reducing payment rates, however, could result in HMOs reducing enrollees' benefits or earning less.

To achieve the expected 5-percent program savings, HMOs would have to be paid at no more than approximately 89.5 percent of the AAPCC. At these levels, payment rates would correct for the differences in enrollee mortality we found between the HMOs and the overall elderly population Medicare serves. We calculated how much it would have cost Medicare to provide the HMO enrollees with services in the fee-for-service sector, by age, sex, institutional status, Medicaid eligibility, and mortality. These calculations were based on the 1978 data published in 1984 by HCFA (see app. I) and on average decedent and survivor costs summarized in table 4.4. We assumed that these data were correct for 1978 and accurately represented the relative distribution of current Medicare program costs between decedents and survivors.

While the phenomenon of HMO enrollees being disproportionately lower users of service than the general Medicare population has been

identified several times in the research literature,[8] it is argued elsewhere in papers cited by Beebe that over the longer term the problem will tend to self-correct, assuming that beneficiaries remain in HMOs for long periods of time. This argument holds that HMO members' health status will gradually "regress to the mean." That is, even if enrollees who initially enter HMOs tend to be lower than average users of medical services, as they age, they are likely to reflect Medicare's overall averages. Thus, the argument goes, HMO enrollees' health status could be disregarded in computing HMO payment rates, as the discrepancy would disappear eventually.

Regression toward the mean does occur, recently completed research[9] on use of services by Medicare fee-for-service beneficiaries over a 7-year period (1974-1980) has shown. But Medicare beneficiaries who were relatively high or low users of Medicare services at the beginning of the period remained above or below the mean, although their use of services did move progressively closer to the mean. Thus, to the extent that behavior of HMO and non-HMO Medicare beneficiaries are similar, the effects of enrolling disproportionately healthy or unhealthy members would be mitigated but typically not eliminated for periods as long as 7 years.

Disenrollees' Use of Hospital Services Average but Costs Lower Than AAPCC Payments

To respond to question 5 (see p. 20) on the subsequent claims experience of HMO disenrollees, we first examined Medicare data on use of hospital services in fiscal year 1984. We found that disenrollees from the 27 risk HMOs used hospital services during the 3 months immediately following disenrollment at about the same rate as all Medicare beneficiaries in the fee-for-service sector (see tables 4.6 and 4.7).

During that 3-month period, 6.6 percent of the disenrollees used a part A service compared with 7.0 percent for all Medicare beneficiaries. On average, HMO disenrollees used $249 in part A services in the 3 months

[8]M Corbin and A Krute, "Some Aspects of Medicare Experience With Group—Practice Prepayment Plans," Social Security Bulletin, Vol. 38, No. 3, March 1975, pp. 3-11,
P. Weil, "Comparative Costs to the Medicare Program of Seven Prepaid Group Practices and Controls," Milbank Memorial Fund Quarterly, Vol 54, Summer 1976, pp 339-365;
P Eggers, "Risk Differential Between Medicare Beneficiaries Enrolled and Not Enrolled in an HMO," Health Care Financing Review, Vol. 1, No 3, Winter 1980, pp 91-99, and
P Eggers and R Prihoda, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in At-Risk HMOs," Health Care Financing Review, Vol. 4, No 1, Sept 1982, pp 55-73

[9]J Beebe, "Medicare Reimbursement Regression to the Mean," Unpublished paper, HCFA, Office of Research and Demonstrations, Feb 1985

following disenrollment compared with $260 used on average by Medicare beneficiaries during any 3-month period in fiscal year 1984.

Table 4.6: Part A Reimbursement for Medicare Disenrollees From 27 Risk HMOs for 3 Months Immediately Following Disenrollment (Fiscal Year 1984)

	Disenrollees		Reimbursement		
Category	No.	Percent distribution	Amount[a]	Percent distribution	Per disenrollee
All disenrollees	15,037	100.0	$3,746,640	100 0	$ 249
Disenrollees with no reimbursement	14,049[a]	93 4	0	0	0
Disenrollees with a reimbursable service	988	6 6	3,746,640		$3,792

[a]For the 27 HMOs analyzed, 73 claims were still being processed as of May 1985, the date of the data file we analyzed These claims had total billed charges of $417,844 We applied a ratio of reimbursement to charges of 5860 percent to estimate an expected reimbursement of $244,840

Table 4.7: Average Part A Reimbursement for 3 Months for All Medicare Beneficiaries (Fiscal Year 1984)

	Medicare enrollees		Reimbursement		
Category	No. (in thousands)	Percent distribution	Amount (in millions)	Percent distribution	Per enrollee
All beneficiaries enrolled	29,759	100 0	$7,747	100 0	$ 260
Beneficiaries with no reimbursement	27,664	93 0	0	0	0
Beneficiaries with reimbursement	2,095	7 0	7,747	100 0	$3,698

For disenrolled Medicare/HMO members in all four Florida risk HMOs, we found a modest range in the average level of part A reimbursement in the 3 months after disenrollment, with a low of $231 per disenrollee for CAC and a high of $299 for HealthAmerica (see table 4.8). For CAC disenrollees, 6.2 percent used a part A service during these 3 months; for AV-MED, IMC, and HealthAmerica, the rates were 6.9, 7.7, and 7.9 percent, respectively.

Table: 4.8: Part A Reimbursement for 3 Months Immediately Following Disenrollment From a Florida Risk HMO, by HMO (Fiscal Year 1984)

		Disenrollees with part A reimbursement	
HMO	All disenrollees: reimbursement per disenrollee	Percent	Reimbursement per disenrollee
National average	$260 32	7 0	$3,697 56
CAC	230 85	6 2	3,717 54
AV-MED	262 72	6 9	3,821 97
IMC	297 30	7 7	3,750 43
HealthAmerica	299 30	7 9	3,875 99

Then, because we believe that the post-disenrollment utilization might have been at least in part attributable to the demographic characteristics of the disenrollees, we compared their total postdisenrollment hospital reimbursements with total AAPCC payments that Medicare would have made had these beneficiaries remained in the HMOs. This is more precise than a direct comparison with part A utilization, because the risk-based HMOs have an under-representation of institutionalized and Medicaid-eligible enrollees, groups that show a high utilization of part A services, as indicated by high AAPCC demographic factors (see table 4.1).

We found that the postdisenrollment Medicare reimbursements were significantly lower than the payments to the HMOs would have been. Between October 1, 1983, and July 1, 1984, 14,097 aged beneficiaries disenrolled from the 27 risk-based HMOs. For this group, total part A reimbursement ($3.0 million[10]) was about 50 percent lower in the 3 months after disenrollment than the HMO payment would have been ($5.8 million) had disenrollments not occurred.

This comparison provides further evidence that, for the group of disenrollees analyzed, the AAPCC would have been too high. But disenrollees may not be representative of those remaining in the HMO. Consequently, we believe that this evidence alone is insufficient to support a conclusion that the AAPCC is excessive. It does, however, raise questions about the accuracy of the AAPCC methodology in estimating Medicare costs.

Potential for Screening and Revenue Supplementation Found

From an HMO's financial perspective, the ideal member would be one who uses no services; the least desirable would be one who uses high levels of service. Although a prohibited practice, screening is one tool for achieving a favorable patient mix.

Because the results of our 1-year mortality study indicated HMOs had a healthier mix of Medicare beneficiaries and also because of several allegations of HMO screening, we decided to identify services provided to Florida HMO Medicare enrollees shortly before their effective enrollment dates. Examining history files for Florida Blue Shield part B claims, we looked for evidence that the HMOs were

- systematically screening new enrollees and/or

[10]Our calculated value was $2 9 million, but this excludes reimbursement for home health services Approximately 3 9 percent of fiscal year 1984 Medicare part A payments were for home health services ($1 6 billion out of a total of $42 1 billion) Increasing the observed $2 9 million by 3 9 percent results in the $3 0 million estimate included in the report

- supplementing HMO capitation payments by providing routine services to new enrollees shortly before their effective enrollment dates, then charging such services to the Medicare fee-for-service system instead of absorbing the cost of the service in the HMOs' capitation payments.

For all four Florida HMOs, Blue Shield had been billed by numerous providers for part B services for between 15 and 54 percent of new Medicare enrollees during the month immediately preceding their effective enrollment dates. One HMO, CAC, had information on the health status of many of its new enrollees, we found, as did two of IMC's affiliated providers. We did not identify any cases where the HMOs acted on such information because our analysis of part B services was limited to individuals that actually enrolled, but the potential for screening existed, as we discuss below.

Screening of New Enrollees by HMOs Alleged

Screening of applicants can be done by either an HMO or an HMO's affiliated providers. In a site visit report prepared prior to OHMO's March 1985 decision to qualify IMC to operate in Broward and Palm Beach counties, an OHMO reviewer who visited IMC affiliated providers observed that:

"Center employees are actively recruiting and enrolling new members. The centers are undoubtedly screening potential enrollees and more actively recruiting those who are in good health."

This matter was never pursued by OHMO.

Similar allegations were made in December 1984, concerning an IMC affiliated provider in Broward County. These resulted from a Florida Blue Shield audit of the center's Medicare claims for services provided prior to the effective enrollment date of new members. In January 1985, HCFA forwarded Blue Shield's findings to IMC for investigation. IMC confirmed, in April 1985, that "noncovered screening" had occurred and the amounts paid by Blue Shield ($1,374) had been refunded.[11] In addition, IMC said it would now treat the date of application by the beneficiary as the effective enrollment date and not bill Medicare for services provided after the application date.

[11]The Blue Shield audit covered the period November 1, 1984-January 31, 1985 Our review of carrier claims' history files showed that, through June 1984, doctors at this IMC center had billed for about $38,000 in allowed charges under the fee-for-service system for 326 IMC members for services during the month immediately preceding their effective enrollment dates in IMC This represents considerably more than the $1,374 refunded to Blue Shield

In this case, the problem may have involved a supplementation of revenues because beneficiaries were told to come to the center between the time they signed up and the effective enrollment date to have physicals and set up medical records. The services were paid by Medicare under its fee-for-service system rather than included in the center's capitation payments to the HMO. On the other hand, because some of the services involved various laboratory tests, chest X-rays, and electrocardiograms, they also indicate that the center had an opportunity to obtain information on the relative health status of beneficiaries prior to the effective dates of their enrollment. We have no information, however, that the center used this knowledge to persuade a beneficiary not to enroll or to disenroll.

In May 1985, other allegations of prescreening were made concerning an IMC-affiliated provider in the Tampa Bay area. IMC investigated these allegations and found them to be unsupported but HCFA did not conduct an independent investigation.

Potentia for Screening Exists, Data Check Shows

In view of this unresolved screening issue and the fact that HCFA had no systematic method of identifying such screening if or when it occurred, we identified new HMO enrollees who obtained part B Medicare services during the month immediately preceding the effective dates of their enrollments. As shown in table 4.9, from October 1982 until June 1984, from 15 to 54 percent of the HMOs' new enrollees had part B fee-for-service billings for services received during the month before the effective dates of their enrollment.

Table 4.9: New HMO Medicare Enrollees Who Had a Part B Fee-For-Service Billing for Services Received During the Month Before Effective Enrollment Dates

	New enrollees				
		Billed for services			
HMO	No. enrolled	No.	Percent	Total allowed charges	Estimated no. of providers[a]
CAC	5,272	2,852	54	$ 428,228	900
IMC	80,186	19,862	25	3,652,007	6,500
AV-MED	9,178	2,434	27	404,274	1,900
HealthAmerica	2,699	401	15	58,164	500
Total	**97,335**	**25,549**	**26**	**$4,542,673**	

[a]These estimates are based on the number of different provider numbers identified during the match, however, the estimates are overstated because a physician can have more than one number or can bill under his or her number or a "Medicare group" number Also, because the same providers served enrollees of more than one HMO, the numbers should not be added

Given the wide range of this occurrence across the four HMOs and the relatively large number of providers involved, we arrayed the allowed charges by provider and, where practicable, consolidated them to determine which physicians or suppliers billed for the most services (in terms of total allowed charges) to these enrollees (see table 4.9). For each of the four HMOs, we selected the five providers generating the most allowed charges and determined the number of enrollees each had seen and whether the providers were affiliated with the HMOs. (See app. III for details of this analysis.)

For CAC and IMC enrollees, the HMO itself was the provider generating the most allowed charges during the month immediately preceding effective enrollment dates. Although we could not conclude that systematic screening was occurring, we did observe that CAC physicians had information on the health status of over 2,000 or about 41 percent of all new CAC enrollees before these beneficiaries entered the risk program. We believe this indicates a potential opportunity for screening although we did not identify any cases where HMOs used the information to avoid enrolling Medicare beneficiaries. Also, the relatively high level of services associated with one IMC affiliated provider raises questions involving screening and/or supplementation of revenues as well as whether the services were medically necessary. These questions are being pursued further by Florida Blue Shield; also, we referred the case to the HHS Office of Inspector General. In addition, another IMC affiliated provider received significant revenues for services to new IMC enrollees during the month immediately preceding their effective enrollment dates.

For AV-MED, three of the top five providers were AV-MED participating physicians at one time or another, although there were no clear patterns of services to preenrollees that indicated potential screening or revenue supplementation. For HealthAmerica, the top five providers appeared to have no connection with the HMO and had billed for only one enrollee each. Therefore, we present no data in appendix III on HealthAmerica.

HMO-Specific Data Needed to Assure Excess Profit Provisions Work

TEFRA includes provisions that serve to limit a risk HMO's profitability in its Medicare line of business to the profitability in its non-Medicare business. Any excess earnings above this level of profitability are called "savings." Savings must be either returned to the government in the form of reduced HMO payments (i.e., payments less than 95 percent of the AAPCC) or provided to the Medicare enrollees in the form of increased benefits.

To safeguard against HMOs unduly profiting from excessive HMO payment rates, HCFA was required by TEFRA to develop the adjusted community rate mechanism, which works as follows. Before the start of a contract period, an HMO with a risk contract must develop and submit to HCFA for its approval an estimate of the premium it would charge on a per capita basis to provide Medicare-covered services to its enrollees for the period.[12] The HMO must begin with an estimate of what it would cost to provide the service package Medicare covers to its non-Medicare commercial lines of business. These private-sector rates are then adjusted to reflect utilization and complexity differences between Medicare and private lines of business. The result is an estimate of the price, minus applicable Medicare copayments, the HMO would charge to provide Medicare-covered services. This ACR is compared with the "average payment rate" (APR), the average of the AAPCC payments the HMO expects to receive, based on HCFA AAPCC rates and the HMO's enrollment projections. The difference between the APR and the ACR is the HMO's "savings" (if the APR is larger than the ACR).

The ACR methodology appears conceptually sound, in our opinion, assuming that HMO-specific data on the costs and utilization of services of both its Medicare/Medicaid and other enrollees are available and accurate. However, our review of 27 risk-based HMOs' ACR submissions to HCFA showed that HCFA has not required all HMOs to use their own utilization data to compute their ACRs. Instead, about one-fourth of the HMOs that converted to risk contracts under TEFRA used a mix of their own data and various national average data to calculate their ACRs. This gives little assurance that these calculations accurately reflect their own projected profitability.

[12]HCFA's HMO/CMP Manual identifies four major steps in the calculation of the ACR (1) constructing a base rate from the organization's revenue requirements that is consistent with the premiums the organization charges its non-Medicare enrollees and allocating it to approved capitation rate components; (2) constructing an initial rate by adjusting the base rate to reflect Medicare-covered services; (3) adjusting the initial rate for differences in utilization between non-Medicare and Medicare enrollees, using approved and documented adjustment factors; and (4) subtracting applicable Medicare deductibles and coinsurance.

Of the 27 demonstration HMOs that converted to TEFRA contracts in April 1985, 7 HMOs[13] used OHMO national or other non-HMO specific data to prepare their first TEFRA ACR applications.[14] The Office of Prepaid Operations, the HCFA office charged with approving ACR applications, performed its reviews with only limited information about these HMOs' actual volume and intensity levels. Only over time, we were told, will they be able to develop an HMO-specific data base.

To function as a mechanism that safeguards against excessive profits, the ACR for each HMO should reflect that HMO's experience. By allowing HMOs to submit ACR applications that contained OHMO or other averages, HCFA has not assured that the ACR safeguard against HMO excessive profits works. We believe that only through the use of verifiable HMO-specific cost, revenue, and utilization data can this safeguard be relied upon to have its intended effect.

Medicare Savings Reduced by Administrative Cost-Loading Factor

TEFRA provides that, under the AAPCC calculation, HMOs be paid 95 percent of the average per capita amount payable under Medicare, including expenses otherwise reimbursable (if there were no HMO program), such as administrative costs incurred by intermediaries and carriers that process and pay hospital bills and physician claims. Currently, HCFA calculates the allowance for administrative costs using an overall Medicare average based on the ratio of cash administrative expenses to cash benefits. This is referred to as the administrative cost-loading factor.

For 1985, HCFA actuaries estimated the claims processing-related amounts (called parts A and B expense-loading factors) at .005089 and .031459, respectively. Weighting these two factors by the total parts A and B cash benefits paid in calendar year 1983 (the year used by the actuaries) yields a weighted average parts A and B expense-loading factor of .0134009, or about 1.34 percent. Thus, for an HMO enrollee having both parts A and B coverage, AAPCC-based capitation payments to the HMO would be approximately 1.34 percent lower had the Congress not defined the AAPCC to include this claims processing loading factor.

[13]IMC, CAC, Central Massachusetts Health Care, Inc , Group Health Plan of Southeast Michigan, Health Care Network, United Health Plan, and Group Health, Inc

[14]According to a HCFA official, only one of the 27 HMOs' ACRs resulted in an HMO electing to reduce its HCFA payments and this reduction amounted to $ 02 per member per month Additionally, two risk-based HMOs originally elected to have their HCFA payments reduced, but each subsequently appealed their ACRs on the basis that they misunderstood HCFA instructions. When these HMOs correctly applied the instructions, their ACRs became high enough to justify the full HCFA payment

HCFA's method of calculating the loading factor will likely result in increasing Medicare's overall administrative costs as a consequence of HMO's involvement with Medicare. This occurs because the administrative costs that the Medicare program would incur for an individual beneficiary or a group of beneficiaries such as HMO enrollees is not the average cost but instead the marginal cost. For example, if those beneficiaries enrolled in HMOs returned to regular Medicare, the carriers and intermediaries would not incur proportionate increases in the fixed cost components of their administrative costs, only in the variable cost components, such as postage and staff time.

In an earlier report,[15] we found from a study of 14 carriers that the ratio of marginal to average costs per claim was 66 percent. More recently, HCFA, in establishing unit costs for intermediaries and carriers for workload increases between 1984 and 1985, assumed a ratio of marginal to average costs of 75 percent. Also, there is some precedent in the Medicare program for reimbursing contractors on a marginal cost basis. In HCFA's most recent fixed-price experiment for Medicare claims processing, the contract provides that the contractor would be paid on an incremental cost basis for processing workloads that exceed HCFA's projections.

Thus, the method HCFA uses to calculate the loading factor results in costs to Medicare that are at least 25 percent higher than the program would be expected to incur if HMO enrollees remained in or returned to regular Medicare. Medicare will also increase its administrative expenses further because intermediaries and carriers continue to have some involvement with risk HMOs, as follows:

1. HCFA's Health Maintenance Organization/Competitive Medical Plan Manual requires HMOs to forward to intermediaries information on bills paid by the HMO for inpatient hospital and skilled nursing facility services. In turn, the intermediary forwards this information to HCFA so it can maintain deductible, coinsurance, and utilization data for each beneficiary. So, even when the HMO does not use the intermediary to actually process and pay hospital claims, there is still intermediary involvement.

2. As shown by our work in Florida, part B claims are frequently submitted in error to carriers for services provided to HMO enrollees. As a

[15] Use of Separate Carrier To Process Medicare Claims for Railroad Retirement Benefits (GAO/HRD-84-54, Sept 26, 1984)

result, carriers incur costs to identify and route such claims to the appropriate HMO.

3. An HMO may elect, under what is called option B, to have intermediaries process part A claims for them. HCFA regulations require that

"Each month HCFA will deduct from the organization's per capita payment an amount HCFA estimates it will be paying to hospitals or skilled nursing facilities on behalf of the organization's Medicare enrollees and administrative costs HCFA incurs in making the payments to the hospitals . . ."

As of June 1986, HCFA was in the process of developing a methodology to estimate the administrative costs. This methodology will be used when making the final reconciliation on payments due to the demonstration HMOs. As a result of the administrative cost add-on, as of November 1985, HCFA reimbursed three option B HMOs in Florida about $521,000 for processing hospital claims that were actually processed by the intermediaries. Because HCFA had also paid the intermediaries for these costs, Medicare paid twice for the same service.

Consequently, HCFA's current average cost methodology for calculating the loading factor is likely to increase Medicare's overall administrative costs. Because of this, in our view, to produce a 5-percent reduction in Medicare's administrative costs HCFA would have to revise its methodology using marginal instead of average costs and also adjusting for contractors' continued involvement with processing HMO claims.

Conclusions

In authorizing Medicare HMO demonstration projects and subsequently expanding the program nationwide, the Congress anticipated that this would reduce Medicare outlays and offer beneficiaries the potential of a more comprehensive benefit package than currently available under regular Medicare. The present method of paying HMOs, however, would reduce program outlays only if the HMOs enrolled and retained a mix of Medicare beneficiaries whose health status at entry closely approximated the health status of the overall Medicare population. To the extent that this occurs, Medicare would save 5 percent because it pays HMOs 95 percent of the average costs of treating Medicare beneficiaries in the fee-for-service sector. HCFA's methodology for paying HMOs does not, however, incorporate a health status indicator; thus, there is little assurance of program savings from the HMO program.

HMO enrollees on average are healthier than the overall Medicare population as indicated by HMOs experiencing only 77 percent of the expected mortality of this group. Because of the average high medical costs of decedents in their last year of life, we estimate that this factor alone offsets the 5 percent "savings" that would occur were HMO enrollees representative, in health status, to the overall Medicare population.

This leads us to believe that, to achieve the savings envisioned when the 95-percent payment rate was enacted, HCFA's methodology for computing payment rates needs to be changed to better reflect the health status of the enrollees. HCFA has not been successful in its efforts to develop a health status adjustment to the AAPCC, but our work shows that prospectively applying a mortality analysis to HMO experience would be one way of taking enrollees' health status into consideration when computing payment rates.

From our review of services Medicare beneficiaries received 1 month prior to their enrollment, we know that the potential for screening out less healthy applicants is available to HMOs. But we have no indication that this in fact occurred, except for one provider that Blue Shield and IMC identified as screening enrollees.

Additionally, HCFA's method for calculating the administrative cost-loading factor is likely to result in an overall increase in Medicare administrative costs. If the HMO program is to produce a 5-percent overall reduction in Medicare costs, including administrative costs, HCFA will need to review its method for calculating the administrative loading factor and consider revising it to better assure that this occurs.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to reduce HMO payment rates to more accurately account for the health status of HMO enrollees, because the methodology used by HCFA to pay risk-based HMOs currently overpays them on average. Our analysis indicates that, in the aggregate, a 5-percent rate reduction would currently be appropriate given the variation in health status as measured by mortality between HMO enrollees and the general Medicare population.

Additionally, we recommend that the Secretary direct the Administrator of HCFA to (1) consider the feasibility of reducing the AAPCC administrative cost-loading factor by recalculating it, using paying agents' marginal costs and a factor to account for paying agents' continued involvement in processing HMO enrollee claims; and (2) collect from the

HMOs payments due for administrative costs under the option B agreements because the intermediaries processed the claims.

Agency Comments and Our Evaluation

HHS disagreed with our recommendations to (1) reduce HMO payment rates to more accurately account for the health status of HMO enrollees and (2) reduce the administrative loading factor to better account for expected Medicare administrative cost savings resulting from HMOs' processing of claims. On the other hand, HHS said it is taking action currently on our recommendation to collect from the HMOs payments for administrative costs when the claims were actually processed by intermediaries. (HHS raised a number of other technical issues with this chapter that we considered in finalizing the report.)

Comments on Our AAPCC Recommendation

HHS does not agree with our recommendation to reduce the AAPCC rates so that they more accurately account for the health status of HMO enrollees. The agency is concerned that our analysis of mortality in 27 risk-based HMOs does not include all appropriate adjustments needed to support a recommendation ". . . that reimbursement to Medicare risk organizations is excessive and ought to be reduced by 5 percent."

We did not recommend reducing payment rates by a specified amount. Instead our mortality analysis was designed to assess, in the aggregate, whether the Medicare risk-based program was achieving the expected program savings. We believe our analysis, based on 27 risk-based HMOs, demonstrates that the overall expected savings are not being achieved. We did point out, however, that our analysis indicates an aggregate 5-percent rate reduction would be needed if the savings anticipated when the Congress enacted TEFRA are to be realized. Our recommendation to HHS is to direct HCFA to make the appropriate reductions in the individual AAPCC payment rates.

Although we acknowledge that making an adjustment for health status is difficult, we believe the differences in mortality rates between HMO enrollees and the general Medicare population need to be addressed if Medicare is to achieve anticipated savings. Because the program is expanding rapidly, it is important that the HMO payment mechanism account for such differences. We believe HHS needs to decide how to best act on our recommendation—whether through the development of a health status adjustment to the AAPCC methodology or otherwise—to better account for the health status of HMO enrollees.

We did not attempt to develop a methodology that would be suitable for adjusting each of the 122 AAPCC rate cells (i.e., individual payment rates based on beneficiaries' age, sex and enrollment status) used to reimburse risk HMOs. HHS' criticisms of our analysis, however, are more directed at problems that they would encounter in using mortality as a basis for adjusting the rate cells than to the basic point of our analysis—an assessment of whether expected program savings are being achieved. For example, HHS is critical of our use of data (based on HCFA research) showing that those Medicare beneficiaries who are in their last year of life incur expenses 6.2 times higher than those who survived. HHS believes we should have developed such a factor for each beneficiary category and by cause of death. While this might be true if we were developing a methodology to adjust each of the 122 rates, it is not necessary when analyzing the overall effect on Medicare payments of the HMOs' lower-than-expected mortality.

Our analysis does not look at the effect of lower-than-expected mortality on individual rates, only on aggregate payments. Consequently, we continue to believe the data demonstrates that the Medicare program is not likely to achieve the anticipated savings and thus that HHS needs to revise the AAPCC methodology or otherwise adjust HMO payment rates to better assure that anticipated savings are realized.

In any case, HHS raises three technical criticisms regarding our methodology for comparing actual and expected HMO enrollee mortality rates. Specifically, HHS was concerned that our methodology did not

- adjust for geographic differences in mortality rates;
- consider the impact on mortality rates occurring because of HMOs' limited enrollment of individuals with end-stage renal disease; and
- demonstrate a significant statistical difference between the actual and expected mortality results we presented.

Our response to these three technical points and to other HHS comments on our methodology follows.

Adjustments for Geographic Mortality Rates

We do not agree that an adjustment for geographic differences in mortality would be appropriate. In preparing our report, we considered making state-wide adjustments for mortality but concluded that national data were more appropriate. State-wide mortality data are published by the National Center for Health Statistics (NCHS), and these data have three limitations:

1. First, Florida (the state having the largest Medicare HMO enrollment in our analysis) has the second lowest mortality rates of any state in the nation and in 1980 experienced 83 percent of the national mortality rate for age 65 and over. But this experience is not consistent with other states in the region and according to NCHS, "The Southeast is by far the largest geographic area in the United States with high [mortality] rates. . . which we [NCHS] have called 'the enigma of the Southeast'. . . ." Considering this evidence of distinctly opposite mortality patterns between Florida and the region, potential migration of elderly persons in and out of the state, and the difficulty in correctly assigning place of usual residence, we believe national mortality rates are superior for comparison purposes in Florida.

2. NCHS mortality rates come from different sources producing overall error rates that would not occur in using Medicare-only statistics as we have done. Specifically, according to a critique of Medicare's and NCHS's mortality statistics, which appeared in the Society of Actuaries' Transactions, " .[NCHS's] central death rates are a composite of the number of deaths as compiled by the Center from the death registration data and the population estimates prepared by the Bureau of the Census on the basis of census counts. The two basic sources of information are different in nature and are subject to different errors. When data from the two are combined, the calculated death rates are subject to the errors of both sources. This is not the case when both number of deaths and population are obtained from the same source, such as medicare."[16]

3. Only national age and sex-specific mortality tables are published for the Medicare population. If published state tables were used for those over 65, non-Medicare elderly would have been included. Additionally, a comparison of Medicare and NCHS age-adjusted rates over the 1968-1978 period, also published by Wilkins in the Society of Actuaries' Transactions (p. 11) indicates that the Medicare central death rates were generally lower. In this case, a conservative approach would favor the use of Medicare mortality data (although only slightly).

Adjustments for Elderly ESRD Beneficiaries

We agree that an ESRD adjustment would have been appropriate if data were available to make it. According to statistics for 1983 in a forthcoming HCFA research report, approximately 19,000 elderly Medicare beneficiaries or 0.07 percent of the total Medicare population had end-stage renal disease. Data to adjust for mortality of this group are not

[16]J Wilkin, "Recent Trends in the Mortality of the Aged," Transactions, Vol XXXIII, 1981, p. 14.

available in a form that allows us to make an aggregate adjustment to our mortality results. Within the aged Medicare ESRD population, however, data are available for those 61 to 70 and 71 years and older who were receiving dialysis. If the 71 and older mortality rate were applied uniformly to all Medicare ESRD beneficiaries age 65 or older, we estimate that the net impact on our estimated difference between actual and expected mortality (77 percent), would be an increase of about 0.5 percent. This would not alter our conclusion that, in the aggregate, our mortality analysis shows HMO payment rates overstated by about 5 percent. (The estimate would change from about 5.5 percent to 5.0 percent.) We would expect the changes in our results to be less than this, however, because to the extent that any of these ESRD beneficiaries were either Medicaid-eligible or institutionalized, we have already accounted for them in part in our analysis.

Adjustments for Statistical Differences

We do not agree that it is necessary to demonstrate that there was a significant statistical difference between the actual and expected mortality results we presented. We did not perform statistical testing on our overall mortality results because they were not sample statistics but rather population parameters based on all deaths for those enrolled in the 27 risk-based HMOs analyzed.

Other HHS Comments

HHS also commented that, even if our mortality comparison were valid, our method for defining the relationship between health care costs and mortality rates is subject to a large degree of error. We believe that our methodology for estimating the 5-percent difference due to the variation in mortality we noted is conservative. As HHS points out, our estimates use the results of a 1984 HCFA study (which used 1978 data) showing that, for age 67 and older, Medicare beneficiaries in their last year of life incur Medicare expenses 6.2 times those who survive.

In addition to using the 6.2 Medicare expense factor, we also used the 5.9-percent overall Medicare mortality rate cited in the HCFA study to calculate our estimate of program savings. Because mortality rates have been declining since 1978, we arguably could have trended the rate forward and doing so would decrease it from 5.9 to about 5.3 percent. If we had used this lower value, our estimate of the aggregate payment reduction necessary for Medicare to achieve 5-percent savings would increase from about 5 to about 7.5 percent. We did not make this adjustment, however, because the HCFA study has not been updated to provide more recent expenditure data. Consequently, we believe it more appropriate

to use both the expenditure and mortality data from the same time period.

While HHS acknowledges that biased selection is a potential problem, it commented that there is evidence that some risk HMOs are experiencing adverse risk selection because of the more comprehensive benefits they are providing. We recognize that this is possible and view it as another reason that HHS needs to revise its payment methodology to more accurately account for enrollees' health status. We have therefore modified our recommendation to clarify that, while we believe rates currently should be reduced in the aggregate, we are not necessarily suggesting across-the-board reductions.

Although HHS does not agree with our methodology, it commented that it supports continued investigation of ways to adjust HMO reimbursement for enrollees' health status and pointed to two studies underway to examine this. We believe that it is necessary to develop such an adjustment soon because adjusting rates, in our opinion, will become correspondingly more difficult as the program continues to expand and both the HMOs and the beneficiaries who join them develop expectations based on reimbursement levels that may not be sustainable if the Congress continues to expect 5-percent savings.

Comments on Our Administrative Cost Recommendations

HHS also disagreed with our recommendation to reduce the AAPCC administrative cost-loading factor by recalculating it using paying agents' marginal costs and a factor to account for paying agents' continued involvement in processing HMO enrollees' claims. HHS commented that it does not believe that either the legislative language of section 114 of TEFRA or the committee language supports the position that the loading factor was intended to pass on to HMOs administrative costs that would be saved because carriers and intermediaries would no longer be involved in processing HMO enrollee claims.

We agree that neither the legislative language nor its history dictate that HCFA should compute the administrative cost-loading factor using marginal costs, and we have modified our report and the recommendation to better reflect this. However, the loading factor, as presently calculated, will likely result in an overall increase in Medicare administrative expenses above those which would be incurred without the HMO program. And, these increased costs will at least in part offset the reductions in Medicare costs anticipated by contracting with HMOs.

Consequently, we believe HCFA should review its methodology for calculating this factor.

HHS commented that it was acting on our last recommendation to collect from the HMOs payments due for administrative costs under the option B agreements. Our discussions with HCFA officials on June 19, 1986, indicate that HCFA is in the process of developing a methodology to do this and should begin collecting these payments from HMOs in the next 2 or 3 months.

HMO Comments and Our Evaluation

Each of the four Florida HMOs were asked to comment on our draft report. IMC, after reviewing the report, advised us that it decided not to comment. Of the three HMOs commenting, all expressed concerns with our recommendation to reduce the payment rates to more accurately account for the health status of HMO enrollees. Their specific comments and our evaluation follow.

AV-MED Comments

AV-MED commented that the south Florida HMOs had provided savings to both Medicare beneficiaries and to the taxpayers. It stated that, if Medicare, desiring to save more dollars, reduces payments to HMOs, it is likely that premiums will be charged to Medicare beneficiaries (premiums are commonly charged by HMOs in other parts of the country) and enrollment will decrease. AV-MED also pointed to losses it had experienced in the Tampa Bay area that resulted in its decision to terminate its TEFRA contract in that area. AV-MED stated that it was likely that an 89 percent of AAPCC payment level would result in its terminating its Miami-based programs.

We agree that the comprehensive coverage offered by HMOs in south Florida provides savings to beneficiaries. Our methodology, however, was designed to assess whether the Medicare program is achieving the overall savings to the federal government envisioned by reimbursing HMOs 95 percent of the AAPCC. As discussed in our evaluation of HHS' comments, we continue to believe that our mortality analysis shows that Medicare, under the present payment methodology and enrollment patterns, is not likely to achieve aggregate program savings.

Additionally, TEFRA requires payments to risk HMOs to be based not on their costs of treating a group of Medicare enrollees but rather on what it would have cost to treat that group of enrollees had they not enrolled in the HMO, i.e., continued in the fee-for-service sector. Our report

acknowledges that lowering AAPCC payment levels would likely reduce enrollee benefits or profitability for the HMOs.

Additionally, AV-MED was concerned that our methodology did not

- consider that south Florida enrollees might not be similar to those in the rest of the nation;
- demonstrate that mortality rates were a valid indirect measure of health status and associated health costs; or
- consider risk to the HMO.

We addressed AV-MED's first point in our discussion of HHS' comments on page 79. Regarding the second point, the relationship between mortality rates and health costs for the Medicare population is clearly established in the HCFA research we used as the basis for our estimates of the effects of the HMO enrollees' lower-than-expected mortality rates on Medicare savings (see p. 63). This research shows that decedents incurred Medicare costs that were on average 6 2 times higher than costs for those who survived; it establishes that on average mortality rates and health costs are directly related. Additionally, because those who are in their last year of life incur such high medical costs, we believe it is reasonable to assume that in the aggregate there is a relationship between mortality and health status. On AV-MED's last issue, we believe that, if health status were more fully accounted for in the payment methodology, risk would decline because HMOs that did experience adverse selection would receive higher payments.

AV-MED's comments are included as appendix V.

CAC Comments

CAC expressed concern that our methodology was based on mortality data for only a single year and was too limited to demonstrate the need for the introduction of a health status indicator.

Our study was based on an analysis of 27 of the 32 risk-based demonstrations that converted to TEFRA risk contracts and included all HMOs that were operational in 1984 and had sufficient data for reliable analysis. We believe that a study of this magnitude was sufficient to assess whether, in the aggregate, Medicare's anticipated savings from HMO payments were being achieved. We recognize, however, that as more HMOs come into the program and those already operating continue to grow, the mortality results we found could change.

In disagreeing with the development of a health status adjustment, CAC referred to the preamble to the final TEFRA regulation in which HCFA reported that it had considered including a health status factor in the AAPCC methodology, but, stated, ". . . [a]n independent actuarial consultant has advised us [HCFA] that a health status adjustment would not result in improvement in the AAPCC methodology . . .."

Although the referenced actuarial consulting firm did reject a health status adjustment, at the same time it pointed to serious problems with the AAPCC methodology. Specifically, the consulting firm concluded that:

"Given the state of the art in manual rating systems within the health insurance industry, the current AAPCC procedures represent the best that can be implemented with an effective date of October 1, 1983

"A manual rating classification system, like that underlying the AAPCC, cannot currently be designed and constructed in a way which will not remain subject to some element of antiselection. Such antiselection may result in payments to risk-basis HMO's that are not actuarially equivalent to average costs in the non-HMO service area.

"From a technical standpoint, a number of deficiencies with the current AAPCC cannot be overcome easily "

Again, we continue to believe that our analysis provides evidence that HHS should revise the AAPCC methodology or otherwise adjust HMO payment rates to account for differences in HMO enrollees' health status to better assure that anticipated program savings are achieved.

CAC's comments are included as appendix VI.

HealthAmerica Comments

HealthAmerica commented that, in its opinion, our conclusions concerning the level of payment to HMOs were based on insufficient data to support the statement that HMOs are reimbursed at too high a level for the services rendered. Our recommendation is not based on a comparison of payments to HMOs and services rendered, but rather on an assessment of whether anticipated program savings were being achieved by paying 95 percent of the AAPCC levels.

HealthAmerica also commented that review of its ACR submittals (i.e., their proposed Medicare premiums) would indicate that they are underpaid. We do not believe that an ACR review will indicate whether over- or under-payment is occurring. The ACR is the HMO's estimate of the

premium it would charge on a per capita basis to provide covered services to its Medicare enrollees for the Medicare contract period. As required by TEFRA, payments are required to be 95 percent of payments that would have been made if the enrollees of an HMO had remained in the fee-for-service sector. The ACR mechanism helps assure that excess payments result in increased Medicare enrollee benefits or reductions in Medicare costs—not excessive HMO profits. While HealthAmerica's ACR does indicate it could have charged its Medicare enrollees a premium, it does not demonstrate Medicare underpayments.

HealthAmerica's comments are included as appendix VII.

Progress Made in Coordinating HMO and Regular Medicare Programs

When a Medicare beneficiary joins an HMO, his or her effective enrollment date and other information is recorded in an automated information system. HCFA uses this system to communicate with the carriers and intermediaries who pay bills for Medicare. Time lags in notifying these paying agents contributed to about $1.3 million in duplicate Medicare payments for physicians' services to HMO beneficiaries in Florida, which we discussed in our March 1985 report. Also, as discussed in that report, delayed notification sometimes meant that the system had incorrect information on membership status for enrollees who were admitted to a hospital.

HCFA now appears to have corrected the time-lag problem by arranging to post enrollment information to the system on or before the enrollment dates. For the period April 1-November 1, 1985, we found essentially no lags between the effective dates of enrollment in the HMOs and the recording of such information.

Not sufficiently resolved was the need for coordinating HMO and regular Medicare payments to physicians and hospitals for enrollees' care. In 1985, we reported that we could not always locate claims at the HMOs for physician services that Medicare denied because the patient was an HMO enrollee; without these claims the HMO cannot make a determination on whether it should pay them. Also, we could not always locate records at the HMOs for Medicare payments to hospitals for HMO enrollees; without these records, the HMOs would not pay specified cost-sharing amounts for the enrollee. Although HCFA has reviewed these problems with Medicare carriers and intermediaries, as of March 1986, it had not tested the HMOs' internal controls to assure that they are aware of and accountable for such bills.

Another problem we noted in our March 1985 report was that of determining responsibility for the medical expenses of Medicare beneficiaries "in transition" into or out of HMO membership. When we examined records for the Florida demonstration HMOs, it was unclear at times who was responsible for a payment—the beneficiary, the HMO, or Medicare. The Congress enacted legislation to resolve the problem of who pays for enrollees' costs when they are in the hospital on the date of enrollment; Medicare was made responsible for the hospital bills. For disenrollments, the HMO is responsible for hospital bills when the beneficiary's date of hospital admission is prior to the effective date of disenrollment. The Congress also reduced the time allowed for HCFA to disenroll beneficiaries from HMOs (formerly from 4 to 8 weeks) to a maximum of 4

weeks, and required that an HMO give the beneficiary a copy of the disenrollment form, which specifies when the disenrollment becomes effective and he/she may begin to use the regular Medicare program. This should lessen problems disenrollees experienced during the disenrollment waiting period.

The magnitude of enrollment/disenrollment and related administrative problems we identified in Florida may not be typical of all HMOs that enroll Medicare beneficiaries. Generally, the Florida HMOs experienced much higher levels of enrollment/disenrollment activity than HMOs elsewhere. Also, in Florida HMOs, the length of time most disenrolled Medicare beneficiaries had been members was 1 to 3 months. This suggests that individuals who decided to return to the regular Medicare program did so rather quickly after enrollment.

Additionally, we analyzed the effect of the HMOs' "lock-in" provision on Medicare enrollees in Florida who obtained "out-of-plan" physician services (services not authorized by the HMO, including those that may have been emergencies). The most significant financial effect of this provision, we found, was experienced by a relatively few enrollees.

Enrollments/ Disenrollments in Florida HMOs Higher Than Elsewhere

In 1984, more Medicare beneficiaries enrolled in the HMO demonstrations in Florida than in those in the rest of the nation combined, according to HCFA statistics. But Florida's rate of disenrollments (20 percent) also was the highest in the nation—over twice as high as all other states except California (see table 5.1). We believe the comparatively high disenrollment rate could indicate beneficiary dissatisfaction with the HMO-type delivery system and services. It also could be attributed, however, to the transient nature of Florida's elderly population—a condition unique to the state. Further, Florida HMOs' higher levels of enrollment and disenrollment may have caused their related administrative problems (which we discussed in our 1985 report) to be proportionately more severe than elsewhere.

Medicare enrollments and disenrollments in 1984 for the five Florida demonstrations are compared in table 5.1 to demonstration HMOs elsewhere in the country (also, enrollments are shown as of December 31, 1983). To provide a geographical basis for comparison, we show data for the 26 demonstration projects started between 1982 and 1984 as well as six earlier demonstrations started in 1980 and 1981.

Table 5.1: Medicare Enrollments/ Disenrollments in Florida Demonstration HMOs Compared With Other Demonstration HMOs (1984)

State/HMO	No. of HMOs	Medicare enrollees: As of 12/31/83	Medicare enrollees: New (1984)	Medicare enrollees: Total	Disenrollments (1984)	Disenrollments as percent of total enrollees
Florida:						
IMC		28,814	96,187	125,001	24,374	19 5
AV-MED		2,634	12,592	15,226	4,021	26 4
CAC		3,045	2,654	5,699	756	13 3
HealthAmerica		1,883	1,596	3,479	779	22 4
South Florida Group Health		•	525	525	48	9 1
Subtotal, Florida	**5**	**36,376**	**113,554**	**149,930**	**29,978**	**20.0**
Remainder of nation:						
Minnesota	4	27,676	26,923	54,599	5,254	9 6
California	4	2,444	22,070	24,514	3,442	14 0
Massachusetts	5	7,243	12,032	19,275	950	4 9
Michigan	5	2,841	6,018	8,859	492 5 6	
Ohio	2	•	7,245	7,245	121	1 7
Illinois	2	•	5,780	5,780	312	5 4
Five other states	5[a]	7,777	9,452	17,229	1,033	6 0
Subtotal, other states	**27**	**47,981**	**89,520**	**137,501**	**11,604**	**8.4**
Total	**32**	**84,357**	**203,074**	**287,431**	**41,582**	**14.5**

[a]Indiana, Maryland, New Jersey, New York, and Oregon

Source HCFA monthly capitation reports used to compute capitation payments to HMOs

Because disenrollments are one indicator of beneficiary dissatisfaction, we analyzed HMO Medicare membership data from the start of the demonstrations through March 1, 1984, for three Florida HMOs and through March 12, 1984, for a fourth Florida HMO to determine how long individuals who disenrolled had been members.[1] As table 5.2 shows, the average period of enrollment varied from 2.2 months for AV-MED members to 5.3 months for CAC members. In a majority of cases, however, beneficiaries who did disenroll were members of the HMO for 3 months or less. In view of the waiting period involved in disenrolling from an HMO under the demonstrations (2-6 weeks), this shows that at least in Florida most of those who left the HMO decided to do so in a relatively short time.

[1]For the purpose of this analysis, we used disenrollments where the enrollment and disenrollment dates on the HMOs' and HCFA files agreed The samples were large enough to achieve a plus or minus 5-percent error at the 95-percent confidence level For HealthAmerica, we analyzed 100 percent of the disenrollments

(For disenrollees who were HMO members for only 1 month, the wait generally meant that they had applied for disenrollment during a period ranging from 2 weeks before to 2 weeks after their effective enrollment dates. This would not have given them much time to use the HMO services.)

Table 5.2: Length of Membership of Disenrollees in Four Florida HMOs

Months of membership	AV-MED 1,303 disenrollments		HealthAmerica 405 disenrollments		IMC 9,984 disenrollments		CAC 752 disenrollments	
	Percent	Cumulative	Percent	Cumulative	Percent	Cumulative	Percent	Cumulative
1	50 0	50 0	16 8	16 8	24 0	24 0	13 2	13 2
2	29 8	79 8	22 5	39 3	16 6	40 6	16 9	30 1
3	4 4	84 2	13 3	52 6	13 7	54 3	11 2	41 3
4 thru 6	9 4	93 6	22 0	74 6	20 2	74 5	24 9	66 2
7 thru 9	4.1	97 7	12 8	87 4	9 7	84 2	16 5	82 7
10 or more	2 3	100 0	12 6	100 0	15 8	100 0	17 4	100 0[a]
Average months of enrollment	2 2 months		4 5 months		4 8 months		5 3 months	

[a]Does not add due to rounding

Why did these beneficiaries disenroll so quickly? We analyzed a random sample of disenrollments for three of the four Florida HMOs for disenrollments between the start of the demonstrations and March 1, 1984. At the fourth HMO, we analyzed all the disenrollments for those between the start of the demonstration and March 12, 1984. Our analysis (see table 5.3) showed that some of the principal reasons stated for disenrollment were: (1) beneficiaries desired to have their own physicians, (2) beneficiaries moved out of the HMO service area, and (3) beneficiaries were dissatisfied with HMO services.

Table 5.3: Reasons for Disenrollments From Four HMOs

Figures Are Percentages

Reason	IMC	AV-MED	CAC	Health-America
Preference for own physician	28 2	42 5	12 5	7 8
Dissatisfaction with services[a]	10 7	9 5	[b]	18 5
Misunderstanding of plan	3 1	3 4	2 8	5 2
Inconvenient access to clinic or choice of hospital	5 6	[b]	[b]	8 0
Joined another HMO	[b]	2 2	1 5	15 1
Financial reason[c]	[b]	3 1	None	4 0
Moving out of service area	19 3	8 9	5 2	10 1
Extensive travel out of service area	7 4	1 5	[b]	2 1
Deceased	2 3	[b]	2 4	5 0
Disenrollment form missing	8 9	13 2	2 4	5 5
No reason or reason not clear	5 9	7 7	69 1[d]	15 1
Other	8 1	6.5	2 8	3 6
Total	**99.5**	**98.5**	**98.7**	**100.0**

[a]Includes a variety of reasons such as dissatisfaction with the turnover of physicians, difficulties and delays in obtaining services, unsatisfactory glasses or hearing aids, or rudeness of HMO staff

[b]Less than 1 percent

[c]Includes termination by HMO for nonpayment of premiums or a desire by the beneficiary to avoid the premiums

[d]We cannot explain why so many CAC disenrollees failed to provide reasons on their disenrollment forms

At HealthAmerica, dissatisfaction with services was the principal reason stated for disenrollment. Moreover, a larger percentage of those disenrolling gave this reason than in the other three HMOs. This seems consistent with OHMO's findings from its April 1984 evaluation that HealthAmerica had problems with waiting times and availability of physicians. The problems had been resolved by March 1985.

Actions Taken to Resolve Enrollment and Disenrollment Problems

Since our 1985 report, HCFA and/or the Congress have taken certain actions that address the problems we identified concerning (1) lack of coordination between the Florida HMOs and Medicare that resulted in duplicate or other erroneous payments to the HMOs, hospitals, physicians, or beneficiaries, (2) determination of responsibility for the cost of services provided to beneficiaries who were in the hospital on the effective date of their enrollment, and (3) beneficiaries who went out-of-plan to obtain services after signing disenrollment forms, but were "locked

in" to HMO-provided services (unless "emergency" or "urgently needed"[2]) until the disenrollment was effective.

Coordination of Records and Payments

In our 1985 report, we identified three problems relating to coordination of records and payments that affected Medicare beneficiaries enrolled in the four Florida HMO demonstration projects.

Of these three problems, in our opinion the most critical involved time lags in recording HMO enrollments on the files HCFA used to advise its paying agents of beneficiaries' enrollment status because this could affect all HMO members nationwide. The other two problems concerned the transfer of certain claims or bills for enrollees from the Medicare carrier or intermediary to the HMO. These problems may or may not affect all HMO members depending on the procedures used by each carrier, intermediary, and HMO. These three issues and how they have been addressed are discussed below.

Time Lags in Recording Enrollment

In March 1985, we reported that HCFA's time lag in posting enrollments in 1984 ranged from 16 to 37 days after the effective date of the enrollment. This contributed to "duplicate" payments by the Florida carrier involving allowed charges of about $1.3 million for physicians' services and to incorrect information being given the intermediary responsible for hospital bills as to the beneficiaries' HMO enrollment status. When HCFA does not give intermediaries correct HMO enrollment information, various hospital-related payment errors can occur, because intermediaries use this information to determine who pays for the services provided—the HMO or Medicare.

As of April 1985, these lags essentially had been eliminated (see table 5.4), and we believe that HCFA has corrected the problem.

[2]The four HMOs reviewed had procedures for their enrollees to obtain emergency or urgently needed services The procedures generally directed Medicare enrollees to go to the nearest medical facility for treatment and notify the HMO as soon as possible AV-MED and IMC have 24-hour toll-free phone lines for their members to contact the HMO, and CAC and HealthAmerica instruct their members to call the member services' hotline collect

Table 5.4: Time Lags in Recording HMO Enrollments in HCFA Files (1985)

Florida HMO beneficiaries enrolled[a]	Effective enrollment dates	Dates posted	Time lags (days)
7,126	January 1	January 18	18
8,794	February 1	February 15	15
7,743	March 1	March 20	20
6,206	April 1	April 1	1
5,370	May 1	April 29	•
4,388	June 1	May 31	•
7,318	July 1	June 28	•
5,051	August 1	July 29	•
4,570	September 1	August 30	•
5,068	October 1	September 30	•
6,841	November 1	October 30	•

[a]Although only the number of Florida beneficiaries enrolled are shown, this problem applied nationwide

Transferring Denied Physician Claims to HMOs

When a Medicare beneficiary is enrolled in an HMO, payment of authorized physician services is the responsibility of the HMO. If the process is working correctly, carriers should not receive any claims for authorized services to HMO members. Nevertheless, claims for such services may be incorrectly sent to the carrier For this reason, the carrier is supposed to transfer denied claims to the HMO so that the HMO can review and pay them if they were authorized or if the beneficiary adhered to HMO requirements. However, we examined in detail 64 beneficiary cases with denied claims of more than $5,000, each denied by Florida Blue Shield. We could not locate at the four HMOs claims representing about 40 percent of the submitted charges.

In discussing the problem in our March 1985 report, we concluded that either Blue Shield had not transferred the denied claims to the HMOs (as it was supposed to) or the claims were transferred and the HMOs had lost them. Further analysis indicates that the latter may have been the cause of the problem, particularly at IMC and CAC.[3]

To determine whether Medicare beneficiaries with denied out-of-plan claims of $5,000 or less had similar experiences, we also examined a random sample of an additional 50 beneficiary cases where the gross

[3]In January 1986, IMC advised HCFA that it had a document control system whereby all claims received were assigned a control number and traced from the date IMC received them through the date IMC paid or rejected them As of March 1986, however, HCFA had not tested this system for denied claims transferred from Blue Shield although they plan to do so in the future

amounts of Blue Shield-denied claims ranged from $1,001 to $5,000.[4] Although the overall results were about the same, when we arrayed the data from both groups (114 beneficiaries) by HMO, we noted wide variations in the amounts of denied claims that we could locate at the four HMOs (see table 5.5).

Table 5.5: Comparison by HMO of Claims (Submitted Charges) **Denied by Blue Shield and Located at the HMO**

HMO	Total no. of beneficiaries reviewed	Net denied claims[a]	Denied claims located	Percent of denials located
AV-MED	25	$ 67,041	$ 58,887	88
HealthAmerica	8	22,921	19,347	84
IMC	62	297,665	164,532	55
CAC	19	55,686	19,646	35
Total	**114**	**$443,313**	**$262,442**	**58**

[a]Adjusted to exclude duplicate denials (claims submitted and denied two or more times)

Because, in our opinion, there is no apparent reason why Florida Blue Shield would transfer a lower portion of denied claims to one HMO than to another, we believe that part of the problem may be that IMC and CAC have not adequately accounted for such transfers. Subsequent to our March 1985 report, HCFA discussed this coordination problem with the carrier, but as of March 1986 had not yet tested the control system over transferred claims at the HMO level.

Misdirection or loss of denied claims can lead to sizable beneficiary liability and/or revenue losses to providers. For example, included in our sample of 50 beneficiaries with denied claims ranging from $1,001 to $5,000 was a CAC member also eligible for Medicaid who had applied for HMO enrollment on December 30, 1982, with an effective date of February 1, 1983. From February 14 through February 27, 1983, she was hospitalized and incurred doctor bills of $5,294 for various services including knee surgery. Blue Shield incorrectly paid $870 and correctly denied $4,424. None of these denied claims were located at CAC, so the HMO neither paid nor specifically denied the claims for services provided to its member. Medicaid paid $1,074 and the balance of $3,350 was either written off by the provider or carried as an accounts receivable as of January 1985. This beneficiary disenrolled from CAC effective October 1, 1984

[4]The sampled cases included 14 from AV-MED, 6 from HealthAmerica, 10 from CAC, and 20 from IMC

Transferring Paid Hospital Bills to HMOs

When an HMO serving Medicare beneficiaries does not have a payment agreement with a hospital, the HMO can elect to have the hospital's Medicare intermediary pay the bills for the HMO, then HCFA deducts the payment from the HMO's capitation amounts. In this situation, the intermediary makes the determination as to whether the hospital admission is an "emergency" not requiring HMO authorization.[5] Of the four Florida HMOs, all but CAC had such an arrangement. According to HCFA instructions, the intermediary is supposed to notify the HMO of such payments so the HMO can pay the beneficiaries' cost-sharing amounts. For half the 44 cases involving hospitalizations that we reviewed in detail and reported on in March 1985, we could locate no record of the payment at the HMO, and cost-sharing amounts had not been paid to beneficiaries by the HMOs as they should have been.

After our 1985 report, HCFA verified that Blue Cross routinely sent copies of the paid bills to the HMOs when it made a payment for an HMO enrollee. Since the problem could have been caused by the HMOs losing the bill records, we arrayed the documented payments by HMO and noted that at IMC only 31 percent of the records could be located, but at AV-MED and HealthAmerica 87 percent were located. Possible solutions to the problem would be to test the HMOs' controls over incoming bills and strengthen them where appropriate or require the intermediary to obtain a receipt for bills sent to HMOs. This would provide some accountability for the failure to send or retain necessary documentation and help place responsibility for HMOs' nonpayment of bills for covered services.

Responsibility for Claims During Transition Periods

Some Medicare beneficiaries who enrolled or disenrolled in the four Florida HMOs we reviewed experienced problems with claims for out-of-plan services they incurred, as we reported in 1985. When beneficiaries were hospitalized between the time they applied for membership and their effective enrollment dates and were in the hospital on the effective enrollment date, was Medicare responsible for the cost of services or was the HMO? A second problem involved out-of-plan services obtained by an HMO member who had applied for disenrollment but it was not yet effective. Again, who was to pay? Our findings on these two problem areas follow.

[5]Under TEFRA regulations, emergency services are defined as covered inpatient or outpatient services provided by an appropriate source other than the HMO that may not be delayed without serious effects on the health of the patient. Such services must appear to be needed immediately to prevent the risk of permanent damage to the enrollee's health.

Costs of Hospitalization Before Effective Date of Enrollment

Our analysis of the claims of 64 beneficiaries who had obtained potential out-of-plan physicians' services of more than $5,000 identified 7 who were in the hospital on their effective dates of enrollment. Although the regular Medicare program covered most of the hospital bills, Medicare denied most of the related doctor bills because the individual was admitted prior to the effective HMO enrollment date. Because the HMOs had not authorized the admissions, their responsibility for these doctor bills was unclear, although the HMOs eventually did pay most of them.

We only found a few of these cases but the financial effect on beneficiaries and their families could be significant. For example, one beneficiary who was in the hospital on the effective date of his enrollment in IMC had paid $5,747 in doctors' bills denied by Medicare for services provided after the effective date of his enrollment. Although Blue Shield had advised the beneficiary that it had transferred the claims to the HMO, we could not locate them at IMC.

The Congress resolved this by making Medicare responsible for the hospital bills in a provision of the Consolidated Omnibus Budget Reconciliation Act of 1985. In such cases, the HMO continues to be responsible for the doctors' bills from the effective date of enrollment.

Costs of Services During Disenrollment Waiting Period

Responsibility for out-of-plan services obtained by beneficiaries during the disenrollment waiting period (between the date the beneficiary signs the disenrollment form and the effective date of disenrollment) was another issue identified in our March 1985 report. Under the HMO demonstrations, this waiting period was 2 to 6 weeks. We examined the cases of 64 individuals with total denied physicians' claims of more than $5,000. Of these, at least 14 began to obtain out-of-plan services on the same day or within a week of the date they signed the disenrollment forms. For example, one beneficiary entered a hospital two days after requesting disenrollment from CAC and incurred $36,180 in claims during the disenrollment waiting period. Of this amount, $26,350 was owed by the beneficiary or written off as uncollectible, and $9,830 was incorrectly paid by Medicare.

Even where lesser sums had been denied, responsibility for out-of-plan services obtained during the disenrollment waiting period was a problem. We analyzed a sample of an additional 50 beneficiary cases where the gross amounts of claims denied by Blue Shield ranged from $1,001 to $5,000. Of the 50 beneficiaries, 14 (about 28 percent) had

obtained their out-of-plan services during the waiting period. Treatment of these cases sometimes varied among the HMOs, as indicated in the following examples.

AV-MED. Five of the 14 cases we sampled involved such services and three of these are discussed below. In the first two cases, the HMO determination favored the beneficiary; in the third, it did not.

1. A Medicare beneficiary signed on January 23, 1984, a disenrollment form stating that he was being treated by a non-AV-MED doctor and was going to a non-AV-MED hospital. The disenrollment was effective March 1, 1984. He had prostate surgery on January 25, 1984. Although, in June 1984, AV-MED initially denied the surgeon's bill of $1,275, the HMO paid it in August 1984.

2. A woman received physicians' services after she applied for disenrollment from AV-MED, but before the effective date. Because AV-MED did not believe that it had processed her disenrollment as promptly as it should have, the HMO paid $692 of the bills.

3. A 52-year-old disabled individual applied for enrollment with AV-MED on February 3, 1983, with an effective date of March 1, 1983. From May 1 to May 3, 1983, she was hospitalized and AV-MED paid the related hospital bill. On May 2, 1983 (while still in the hospital), she signed an AV-MED disenrollment form that included the notation "poor risk" under the reason for disenrollment. The effective disenrollment date was June 1, 1983; however, during the waiting period she was hospitalized (on May 17, 1983) through the emergency room and discharged June 10, 1983. Through May 31, 1983, while still an AV-MED member, she incurred hospital charges of $7,680 and doctors' bills of about $3,061. Of these amounts, Florida Blue Shield incorrectly allowed $1,032 on submitted doctors' charges of $1,296, leaving $1,765 in claims correctly denied by them to be accounted for. AV-MED denied the hospital bill because of a late notification of the admission and $1,609 of the doctors' bills because the admission was not authorized Of the latter, $769 was due the radiologists and pathologists at the hospital. They did not have a record of the charges, so we do not know whether or not they were paid. The remaining $840 was the bill for her attending physician, who told us in February 1985 that he had not been paid.

HealthAmerica. One of the six beneficiaries in our sample at HealthAmerica obtained out-of-plan services during the disenrollment waiting period. This individual applied for disenrollment on August 29,

1983, with an effective date of October 1, 1983. The reason given was to save money by joining IMC. On September 2, 1983, he went to a chiropractor and, as a result of numerous office visits during that month, incurred charges of $1,200. Blue Shield denied these claims because he was still a member of the HMO; HealthAmerica denied them because the services were unauthorized. According to the provider, who was unaware that the beneficiary was an HMO member, he was unable to collect anything.

IMC. In the case of IMC, 7 of the 20 sampled beneficiaries incurred expenses during the disenrollment waiting period. This HMO actually had denied only about 2 percent of the submitted charges that we could locate for potential out-of-plan services and had denied none in these seven cases. However, we could not locate about 38 percent of the IMC claims at the HMO and those that we could not locate were not acted upon and thus were neither paid nor specifically denied. Two of these cases are discussed below. One, where we located the claims, favored the beneficiary; the other, where we could not find the claims, did not.

1. A beneficiary applied for membership on December 21, 1983; it was effective February 1, 1984. In January, however, he requested disenrollment before the effective enrollment date. His effective disenrollment date was March 1, 1984. On February 22, 1984, he was hospitalized for a cataract operation. IMC, which had been notified of this admission, approved it. The Medicare intermediary, Blue Shield, denied $2,265 in doctors bills in March 1984; however, in May and June 1984, IMC settled these claims plus one other claim that was not in Blue Shield's records.

2. A beneficiary's application for enrollment, dated December 14, 1983, allegedly was submitted by her husband. The effective date was January 1, 1984. On January 28, 1984, she signed a disenrollment form stating that she had had a series of heart attacks and would not change doctors. The disenrollment was effective March 1, 1984; however, on February 4, 1984, she was admitted to the hospital on an emergency basis. Blue Shield correctly denied $1,137 in physicians' claims—some involving "critical" care while she was in the hospital plus a later office visit. Of these denials, we concluded that $559 were duplicates of previously denied claims leaving a total of $578 to be accounted for—none of which were located at IMC. We contacted the provider owed $540 and were told that the beneficiary had paid $250 leaving a $290 balance still due. The provider did not know she was an HMO member until notified by Medicare.

CAC. One of the 10 cases we sampled involved a beneficiary who obtained out-of-plan services during the disenrollment waiting period. The individual applied for enrollment on October 15, 1982; it was effective November 1, 1982. She requested disenrollment on October 28, 1982; this was effective December 1, 1982. After requesting disenrollment, she was hospitalized on November 15, 1982. Blue Shield denied $1,258 for physicians' services provided during November 15-26. Of this, $520 represented duplicate denials, leaving $738 to be accounted for. CAC paid the claims with submitted charges of $675. This left $63, which we did not pursue.

Dealing With Services Obtained During Disenrollment Waiting Period

In the Consolidated Omnibus Budget Reconciliation Act of 1985, the Congress also addressed the problems of out-of-plan services during the disenrollment waiting period. The question of who pays for disenrollees' medical expenses when they are in the hospital on the date of disenrollment was resolved by requiring HMOs to pay the hospital bills and Medicare to pay the physicians' bills from the effective date of disenrollment. Additionally, the disenrollment waiting period was reduced to a maximum of 4 weeks. (Under TEFRA, it was 4 to 8 weeks.) Further, HMOs must now give the beneficiary a copy of the disenrollment form and a written explanation of how long the person must continue to use the HMO facilities to have the services covered.

If beneficiaries understood their Medicare appeal rights, however, the problem of their obtaining out-of-plan services during the disenrollment waiting period could be better resolved. As we discuss in chapter 6, HMO members in Florida were not adequately informed of the Medicare appeals process initiated when a beneficiary is denied a Medicare reimbursable service. Before the appeals process begins, the beneficiary must obtain an initial denial and contest it (both in writing). Further, if the Medicare appeals process is properly followed, the last word on payments for out-of-plan services rests with the government—not the HMO.

Relatively Few Enrollees Affected by Denial of Out-Of-Plan Services

Analyzing the financial impact of the "lock-in" provision on Medicare beneficiaries in the four Florida HMOs, we found (as we did previously) that it affected relatively few enrollees in terms of significant beneficiary liability. "Lock-in" means that neither an HMO nor the regular Medicare program will pay for an enrollee's services provided by institutions or practitioners not affiliated with the HMO unless they are "emergency services" or "urgently needed services outside the HMO's service area."

During our examination of HMO and HCFA enrollment records to identify claims for out-of-plan services covered by Medicare part B, we found that a larger number of enrollees reviewed had received such services than we reported previously. In our March 8, 1985, report, we indicated that 6,737 (or 6.4 percent) of the enrollees reviewed had potentially[6] received some out-of-plan physicians' services. However, during a subsequent computer match of HMO and HCFA enrollment records, we discovered that many beneficiaries had not been matched against the Florida Blue Shield payment records. Modifying the program and using HCFA enrollment data, we determined that 20,336, or about 19 percent of the approximately 105,000 beneficiaries reviewed had potentially received out-of-plan services while enrolled in one of the four HMOs (see table 5.6).

Table 5.6: Claims for Out-Of-Plan Medical Services Denied or Incorrectly Allowed by Florida Blue Shield

	Submitted charges for out-of-plan services					
	Denied				Allowed	
Distribution of part B claims denied	No. of beneficiaries	Percent	Amount[a]	Percent	No. of beneficiaries	Amount
$1 to $100	7,714	44 7	$ 376,699	4 9	1,235	$ 303,424
$101 to $500	6,185	35.9	1,459,121	18 8	1,108	333,869
$501 to $1,000	1,521	8 8	1,071,215	13 8	372	147,682
$1,001 to $5,000	1,633	9 5	3,354,851	43 2	448	302,785
Over $5,000	188	1 1	1,499,373	19 3	60	95,722
Subtotal	**17,241**	**100.0**	**$7,761,259**	**100.0**	**3,223**	**$1,183,482**
All out-of-plan claims paid	3,095		[b]		3,095	576,850
Total	**20,336**		**$7,761,259**		**6,318**	**$1,760,332[c]**

[a]Totals eliminate apparent duplicate denials (i e , claims received and denied more than once)

[b]Not applicable

[c]The amounts Blue Shield incorrectly allowed totaled $1,332,047 The comparable amount of allowed charges on page 10 of our March 8, 1985, report was $562,234 Therefore, our earlier report understated the amount of incorrect part B claims paid by the carrier, but overstated the rate of error (29 vs 19 percent)

Of the 105,000 beneficiaries reviewed, 9,527 or about 9 percent obtained potential out-of-plan services of over $100. The remainder either (1) did not go out of plan, (2) obtained services of $100 or less, (3) had all their out-of-plan claims incorrectly paid by Blue Shield, or (4) did not submit

[6]"Potentially" because a review of individual cases showed the Medicare carrier had received claims for services that had been authorized by the HMOs and should have been submitted to the HMOs

any claims to Blue Shield. Further, 3,342 or 3 percent of the beneficiaries screened had denied part B claims of over $500, which represented about 76 percent of the total amounts denied. Thus the most significant financial effect of the "lock-in" provision fell upon a comparatively small number of Medicare enrollees.

Because of the large potential liability incurred by relatively few enrollees, our earlier report focused on 64 beneficiaries we had identified as having total denied part B claims of over $5,000 each. Overall, we learned, about 14 percent of the denied charges had been paid by the beneficiaries, their families, or other parties (such as supplementary insurers). For this report, we sought to determine if this would be similar for beneficiaries having a lower threshold of potential liability, i.e., claims between $1,001 and $5,000. We selected a random sample of 50 of the 418 beneficiaries that we had identified early in our review as having denied claims of such amounts (including multiple denial of claims for the same service) and tried to determine whether the HMO, the beneficiary, Medicare, or another party had paid the claim or whether the provider had absorbed the revenue loss.

Table 5.7: Disposition of Denied Part B Claims by Level of Potential Liability

	Amount of denied claim	
	Over $5,000	$1,001 to $5,000
Number of beneficiaries	64	50
Net denied claims	$373,232	$70,081
Disposition		
HMO paid or was reviewing	53%	41%
Beneficiary family, supplementary insurance, or other paid	13	15
Provider absorbed revenue losses	22	29
Unknown	12	15
Total	**100%**	**100%**

Comparing beneficiaries whose denied claims were $1,001-$5,000 with those whose claims were over $5,000, we found that for both groups, the beneficiaries or others had paid about the same percentage of denied claims as shown in table 5.7. Likewise, the reasons why the HMOs paid or were reviewing the denied claims for both groups were similar. That is, (1) the services had been authorized by the HMO, and the doctors had sent the claims to Blue Shield in error, or (2) when the HMO learned of the denials and the circumstances of the out-of-plan services, it decided to accept financial responsibility for them.

Conclusions

Of the five problem areas identified in our March 1985 report involving HMO enrollment/disenrollment processes, three have either been corrected by HCFA or addressed by the Congress. The remaining two problem areas, which involve the transfers of paid part A bills and denied part B claims from Medicare paying agents to the HMOs, also have been partially addressed by HCFA's review of the paying agents' procedures. Apparently, HCFA is satisfied that its paying agents are not the cause of the high percentage of paid part A bills and denied part B claims not being located at the HMOs, because it had reviewed their procedures for forwarding claims to the HMO. HCFA, however, did not test the internal controls at the HMOs to see whether the controls are adequate to prevent these HMOs from losing or otherwise disposing of documents used to trigger payment actions.

Although the bulk of the problems associated with part B claims denied to HMO members fell on only about 9 percent of beneficiaries enrolled in the four Florida HMOs, the effect on individuals or their families could be significant. Therefore, we believe that it is important that HCFA determine that the Florida HMOs (particularly IMC and CAC because of their low percentage of located claims) have in place adequate internal controls to account for part A bills and part B claims transferred from the intermediaries and carriers.

Recommendation to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to test the Florida HMOs' internal controls over claims transferred to them by the intermediaries and carriers. This could be accomplished by HCFA taking a sample of paid part A bills and denied part B claims recently transferred from its paying agents and verifying that they have been accounted for and appropriately acted upon by the HMOs. Alternatively, the problem could be addressed by requiring the paying agents to obtain receipts for the documents transferred.

Agency Comments and Our Evaluation

HHS agreed with this recommendation, and HCFA is working with its regional offices to develop a standardized protocol that will be used to monitor HMOs' activities and procedures with respect to claims transferred by the intermediaries and carriers

Beneficiaries Not Adequately Informed of Grievance and Appeal Rights

HCFA has not assured that HMOs with Medicare risk contracts fully comply with federal regulations on beneficiary grievance and appeal procedures, which help assure that beneficiaries understand their rights as HMO members. As of September 1985, none of the four Florida HMOs we reviewed were in compliance with HCFA requirements to provide Medicare enrollees with written explanations of Medicare's appeals procedures, and only one HMO was notifying beneficiaries of its internal grievance procedures. Although Medicare regulations governing beneficiary grievance procedures are simple in concept, the process enrollees must follow to initiate a grievance or appeal and obtain a full hearing is not. Without prior knowledge of the process, there is no assurance that enrollees entitled to a hearing of their grievances will know how to begin.

In fact, beneficiaries enrolled in the HMOs reviewed only began using the Medicare appeals process late in 1984. From the time the HMO demonstration began through February 1984 (the latest period for which we have data), no appeals were filed, although about 9,500 Medicare enrollees in these HMOs had claims for physician services in excess of $100 denied[1] by Florida Blue Shield, for a total of $7.4 million. From February through the end of 1984, only two denials by the four HMOs were appealed to Medicare. During the period January 1985-November 1985, 10 appeals were filed. These may be attributable, at least in part, to corrective measures taken by HCFA to assure that more information on the process was given to HMO Medicare enrollees.

Grievance and Appeals Processes Governed by Federal Regulations

The procedures necessary to administer the formal grievance and appeals processes required by federal law and HCFA regulations are complex. Not even HMO officials with whom we discussed the respective HMOs' grievance and Medicare appeals processes fully understood what they entailed and the options available to their enrollees. Unless given an explanation of what is involved, HMO Medicare enrollees cannot reasonably be expected to understand what they must do to initiate and carry through the formal process.

The grievance and appeals processes of federally qualified HMOs with Medicare contracts are regulated under provisions of title XIII of the PHS Act and title XVIII of the Social Security Act (Medicare statute), as discussed below.

[1]We used $100 as a cutoff as claims below this amount cannot be appealed beyond HCFA (see fig 6 1)

PHS Act Regulates HMO Grievance Process

Both Medicare and non-Medicare HMO enrollees are covered by federal HMO regulations implementing the PHS Act as it pertains to enrollee grievance procedures. To obtain federal qualification, an HMO must prepare and provide to its members upon request a written description of its internal procedures for hearing and resolving grievances between the HMO and its members. These procedures must assure that grievances and complaints are transmitted in a timely manner to decision-making levels within the HMO that have authority to take corrective action. With respect to Medicare members, these procedures apply to grievances pertaining to HMO services required by Medicare, as well as optional services provided by the HMO such as eyeglasses and dental care.

Although these procedures include several review levels within the HMO, they provide for no beneficiary appeals process outside the HMO to address conflicts not resolved internally. An external appeals procedure is available under Medicare regulations, however, as described below

Medicare Statute Establishes External Appeals Process

Federal implementing regulations under the Medicare statute describe the grievance and appeals procedures that pertain to HMO Medicare enrollees. These regulations establish an appeals mechanism outside the HMO to address beneficiary grievances not resolved through the HMO's internal grievance process. The HMO must establish and maintain explicit grievance and appeals processes for Medicare enrollees and inform them in writing of the necessary steps to follow

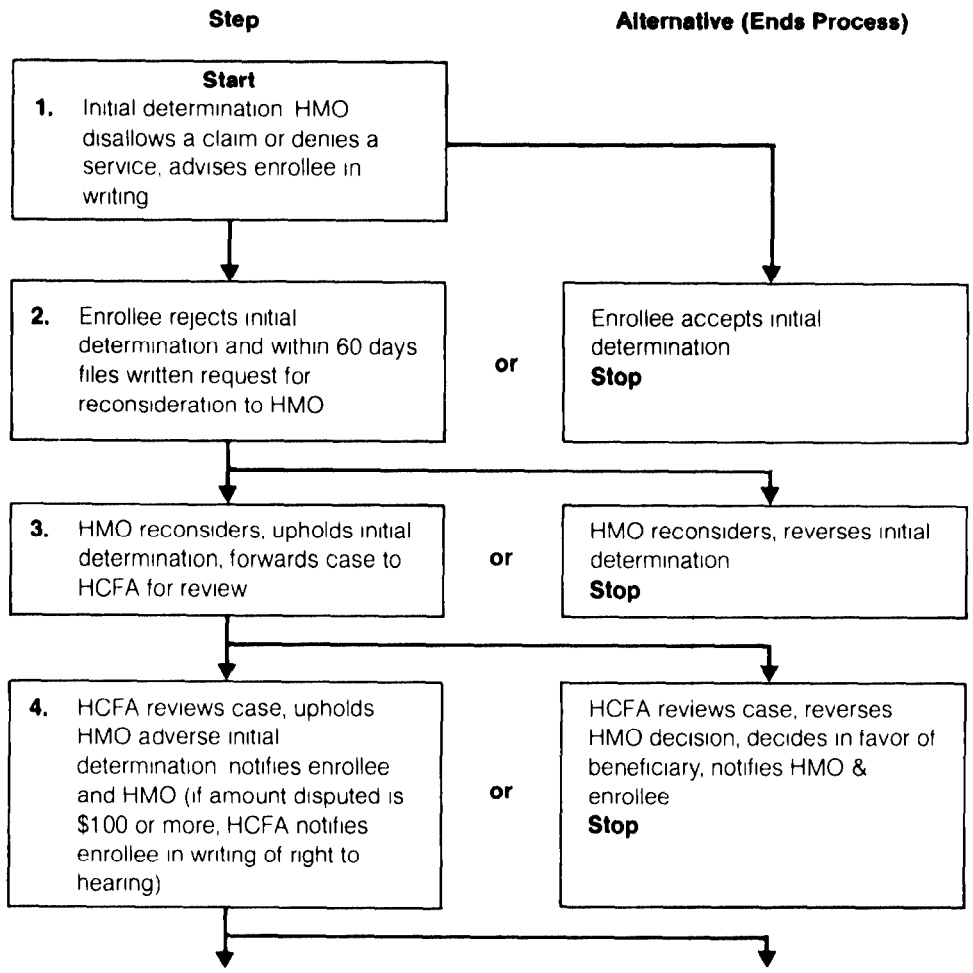
Under Medicare regulations, enrollees may appeal any initial determination (i.e., denial of a service or reimbursement for a service) by the HMO regarding:

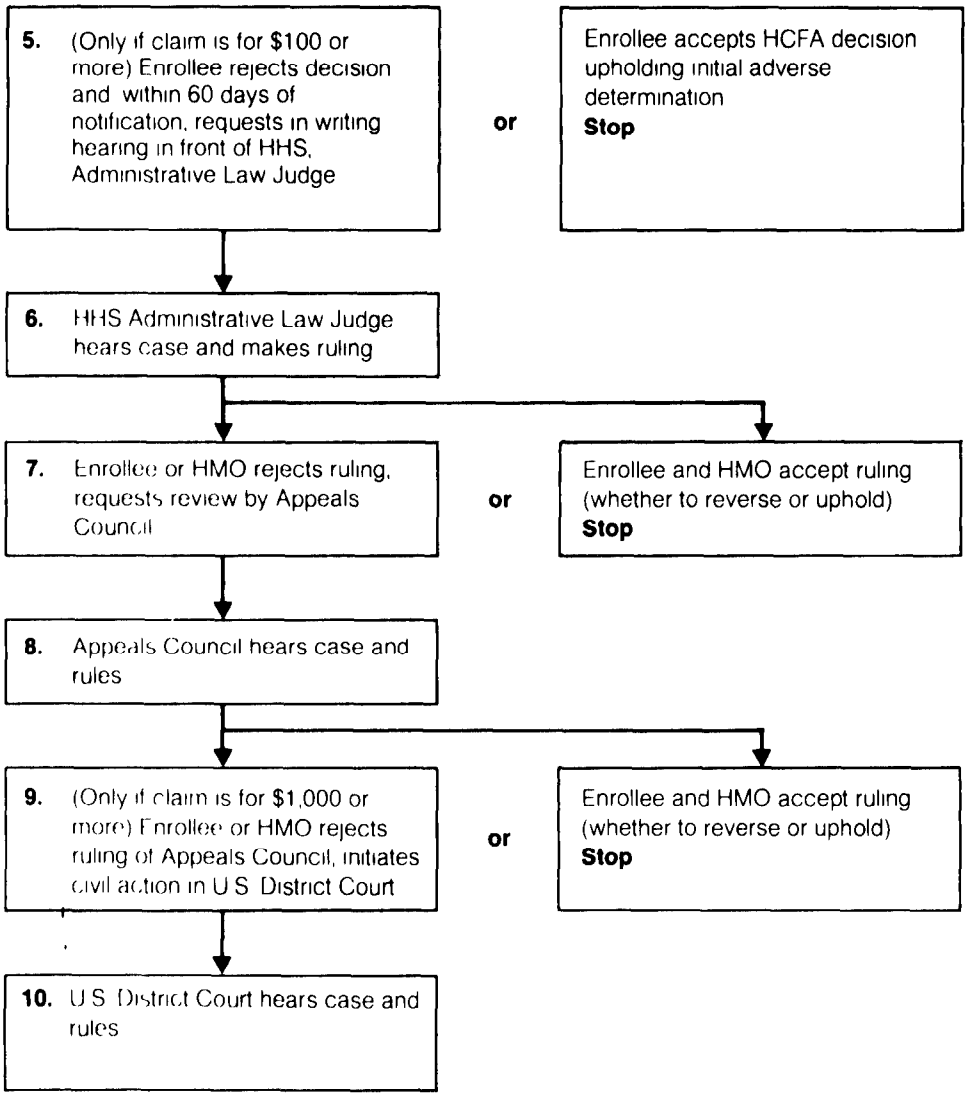
- reimbursement for emergency or urgently needed services;
- reimbursement for any other health services furnished by a provider or supplier other than the HMO that the enrollee believes are covered under Medicare and should have been furnished, arranged for, or reimbursed by the HMO; or
- provision of services the enrollee believes should have been furnished or arranged for by the HMO but were not.

The appeals procedures apply only to services payable under the Medicare program and do not include optional services, which are subject to the grievance procedures established under the PHS Act.

To initiate the Medicare appeals process, an enrollee who feels his or her grievance over a denied service or claim has not been satisfactorily addressed through informal communications with the HMO must obtain, in writing, from the HMO a denial of the claim or request for service. The written denial may also be made by an organization acting on behalf of the HMO, such as an intermediary. The enrollee then asks the HMO or its agency in writing to reconsider the initial determination. If the service or claim is still denied, there are four levels of appeal beyond the HMO. The process is complex, as figure 6.1 shows.

Figure 6.1: Medicare Appeals Process




5. (Only if claim is for $100 or more) Enrollee rejects decision and within 60 days of notification, requests in writing hearing in front of HHS, Administrative Law Judge
or
Enrollee accepts HCFA decision upholding initial adverse determination
Stop
6. HHS Administrative Law Judge hears case and makes ruling
7. Enrollee or HMO rejects ruling, requests review by Appeals Council
or
Enrollee and HMO accept ruling (whether to reverse or uphold)
Stop
8. Appeals Council hears case and rules
9. (Only if claim is for $1,000 or more) Enrollee or HMO rejects ruling of Appeals Council, initiates civil action in U S District Court
or
Enrollee and HMO accept ruling (whether to reverse or uphold)
Stop
10. U S District Court hears case and rules

Enrollees Not Adequately Informed of Rights

As of September 1985, none of the four HMOs we reviewed was complying with regulations that require HMOs to give their Medicare members written descriptions of the Medicare appeals process. Only one HMO was giving its members a written description of its internal grievance process, as regulations require. Three HMOs did, however, notify enrollees that grievance and appeals procedures existed, either by a statement in the plan handbook given new enrollees or in the contract enrollees signed when they became members. But the statements did not explain how the process works.

Also, from the time HMOs began operating as Medicare demonstration projects through calendar year 1984, none of the four when denying claims informed enrollees in writing of their appeal rights, as Medicare regulations require. Through February 1984, about 9,500 Medicare enrollees in these HMOs had claims denied by Blue Shield that individually exceeded $100, totaling about $7.4 million (see table 5.6). During this period, none of these denials were appealed through the established Medicare appeals process. Furthermore, during the remainder of calendar year 1984, only two appeals filed through the Medicare process concerned service denials at the four HMOs.

Under the regulations, more appeals should have been filed as we discuss below. The HMOs, however, did not comply with HCFA regulations requiring them to automatically forward to HCFA all cases they denied a second time after a Medicare enrollee's written request to the HMO to reconsider the initial denial. In 1984, these four HMOs received 10 such requests for reconsideration; in at least five cases, the HMOs upheld their initial denials and should have forwarded the cases to HCFA for its review but did not. As we show in figure 6.1 (step 3), had the HMOs forwarded these cases to HCFA, this would have begun the external Medicare appeals process. From that point on, the enrollees would have been notified of the findings and any further appeal levels available to them. HMO officials told us they did not understand it to be their responsibility to send reconsidered case files to HCFA.

In February 1985, HCFA's Atlanta regional office, which is responsible for monitoring the four Florida HMOs' compliance with federal requirements, instructed the HMOs to begin informing enrollees of their appeal rights in writing at the time any claim was denied. The instructions also explicitly notified HMOs of their obligation to forward all reconsidered denials to HCFA for review. Since that time, all four HMOs have begun doing this, and through November 1985, 10 denied claims have been appealed to Medicare. HCFA's guidance was silent, however, with regard

to the Medicare regulatory requirements to provide Medicare enrollees with written information describing available grievance and appeals processes. And, as mentioned above, only one HMO was in partial compliance with these requirements as of September 1985, while the others were not complying at all.

During the HCFA HMO demonstration period, the four HMOs were required to submit to HCFA their brochures and promotional and informational material dealing with the enrollment of Medicare beneficiaries for HCFA review and approval before issuance. HCFA did not require the HMOs to explain the Medicare appeals procedures in any of these HMO materials. Officials at two of the HMOs reviewed told us that, because of HCFA's approval of these materials, they presumed their HMOs were complying with Medicare's grievance process disclosure requirements.

Because many times beneficiaries attempt to resolve complaints over the telephone or in person, it is particularly important that HMO enrollees understand their grievance and appeal rights. Also, HMOs often attempt to resolve complaints over the telephone, we were told. Because of this, we believe that enrollees unfamiliar with the HMO's and Medicare's grievance and appeals processes may not take the steps necessary to initiate either process when their complaints are not resolved to their satisfaction.

A substantial volume of enrollee complaints that could involve potentially appealable denials was received by the HMOs. During the first 3 months of 1985, two Florida HMOs that had Medicare complaint data readily available received 1,730 such complaints, while another HMO reported 6,502 complaints from both Medicare and non-Medicare members (about 67 percent of its members were Medicare enrollees). Medicare HMO enrollees who are not satisfied with their complaint resolutions and are unaware of Medicare grievance and appeal rights may very well not proceed further.

Conclusions

The Medicare beneficiaries enrolled at the four HMOs reviewed have not often used the HMO grievance and appeals processes established by federal regulations as a safeguard to protect enrollee interests, although there have been a substantial number of claim denials and complaints. One reason these processes are rarely used, we believe, may be that HMOs are not adhering to federal requirements to give all Medicare enrollees written descriptions of their grievance and appeal rights and how these can be exercised. One way to remedy this would be for HCFA

to enforce its requirements that HMOs provide all their Medicare enrollees with such information.

Recommendations to the Secretary of HHS

The Secretary of HHS should direct the Administrator of HCFA to

1. Develop a standardized explanation of the Medicare appeals process and provide it to the HMOs for inclusion in their handbooks or other documents provided to all Medicare enrollees.

2. Give the HMOs guidelines establishing standards they must use in providing information on their internal grievance procedures to all enrollees.

Agency Comments and Our Evaluation

HHS agreed with these recommendations, commenting that this is an important area and one potentially subject to misunderstanding by the plans. HHS commented that misunderstandings by the plans may arise because HMOs only have internal grievance procedures for their non-Medicare beneficiaries but have both grievance and Medicare's appeal procedures for their Medicare beneficiaries. HHS pointed out that it is critical that the organizations be able to distinguish between the two and provide the information not only to the enrollees but to their claims adjudicators as well. HHS said it will develop the necessary guidelines.

Marketing Costs Not Out-Of-Line but More Guidance Needed on Marketing Activities

During the Medicare demonstration period, three of the four HMOs we reviewed spent at least $18 million to market their Medicare plans (the fourth did not maintain separate data on its Medicare marketing costs). This represented about 6 percent of the HMOs' total expenditures under their contracts, which was comparable to their marketing expenditures for their commercial plans.

HCFA required the demonstration HMOs to submit their media advertising materials for its approval prior to use; it also reviewed and approved other material given to enrollees, such as brochures and enrollee handbooks. But under the TEFRA regulations effective February 1985, HCFA no longer required prior approval of such materials.

Now, the Consolidated Omnibus Budget Reconciliation Act of 1985 requires HCFA once again to approve HMO marketing materials before their use. This legislation should help prevent use of prohibited marketing practices, which occurred at the Florida demonstration HMOs and in one instance at an HMO operating under TEFRA provisions. However, HCFA has not provided the new TEFRA projects with sufficient guidance on appropriate or inappropriate marketing activities. We believe additional policy guidance covering the "dos and don'ts" in marketing would help new HMOs to take advantage of the lessons learned under the demonstration project.

Medicare and Commercial Marketing Costs Comparable

Overall, three of the HMOs[1] we reviewed spent at least $18 million marketing their plans to Medicare beneficiaries (about 6 percent of their total Medicare expenditures during the same periods). In comparison, they spent about $33.9 million (about 11 percent) on other overhead costs such as administrative and clerical salaries, leaving about $260.4 million (about 83 percent) for patient care, e.g., doctors' salaries and payments to providers.

IMC spent about $16.7 million on marketing (about 6 percent of its total Medicare costs); AV-MED spent about $891,000 (about 8 percent); and HealthAmerica, about $412,000 (about 4 percent). The amounts each spent during various periods under the demonstration on Medicare-related marketing and other overhead costs and patient care are shown in table 7.1.

[1]Data breaking out Medicare and non-Medicare marketing costs were not available from CAC, the fourth HMO reviewed

We have no basis for judging the reasonableness of the Medicare marketing costs of the three HMOs. But compared with the amounts they spent for marketing under their commercial plans, their overall Medicare marketing costs, as percentages of total costs, were not out of line. The amounts each HMO allocated to Medicare and commercial marketing varied, but again we have no basis for determining whether those amounts were reasonable. The amounts the HMOs spent under their commercial plans for marketing, other overhead, and patient care (for the same periods as table 7.1) are shown in table 7.2.

Table 7.1: Medicare Marketing, Overhead, and Patient Care Expenditures by Three HMOs[a]

	Expenditures (amounts in thousands)									
	Marketing[c]		Overhead		Subtotal		Patient care		Total	
HMO/time period[b]	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
IMC[d],[e]										
8/1/82-12/31/82	$ 881	7 0	$ 2,625	20 7	$ 3,506	27 7	$ 9,165	72 3	$ 12,671	100
1/1/83-12/31/83	2,618	5 1	4,146	8 1	6,764	13 2	44,457	86 8	51,221	100
1/1/84-12/31/84	13,209	5 8	25,312	11 2	38,521	17 0	187,665	83 0	226,186	100
Subtotal	**16,708**	**5.8**	**32,083**	**11.1**	**48,791**	**16.8[f]**	**241,287**	**83.2**	**290,078**	**100**
HealthAmerica[d]										
2/1/83-12/31/83	119	3 3	486	13 6	605	17 0[f]	2,957	83 0	3,562	100
1/1/84-12/31/84	293	3 8	630	8 1	923	11 8[f]	6,883	88 2	7,806	100
Subtotal	**412**	**3.6**	**1,116**	**9.8**	**1,528**	**13.4**	**9,840**	**86.6**	**11,368**	**100**
AV-MED[d]										
10/1/82-09/30/83	414	16 2	94	3 7	508	19 9	2,042	80 1	2,550	100
10/1/83-04/30/84	477	5 7	608	7 3	1,085	13 0	7,270	87 0	8,355	100
Subtotal	**891**	**8.2**	**702**	**6.4**	**1,593**	**14.6**	**9,312**	**85.4**	**10,905**	**100**
Total	**$18,011**	**5.8**	**$33,901**	**10.9**	**$51,912**	**16.6[f]**	**$260,439**	**83.4**	**$312,351**	**100**

[a]According to the congressional request, these expenses were to be compared to revenues Comparing them to revenues distorts the results because the percentage of profit or loss, which would affect the figures, varies by HMO and by time period

[b]CAC officials could not provide expense information for their Medicare program only

[c]Includes marketing and advertising expenses

[d]At the time of our review, these were the only time periods for which information was readily available

[e]Does not include amounts spent on marketing or overhead by the providers that contract with the HMOs

[f]Does not add due to rounding

Table 7.2: Non-Medicare Marketing, Overhead, and Patient Care Expenditures by Three HMOs[a]

	Expenditures (amounts in thousands)									
	Marketing[c]		Overhead		Subtotal		Patient care		Total	
HMO/time period[b]	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
IMC[d],[e]										
8/1/82 12/31/82	$ 0	0 0	$ 1,125	22 3	$ 1,125	22 3	$ 3,919	77 7	$ 5,044	100
1/1/83-12/31/83	2,229	13 6	3,530	21 6	5,759	35 2	10,600	64 8	16,359	100
1/1/84-12/31/84	4,923	14 2	4,301	12 4	9,224	26 7[f]	25,375	73 3	34,599	100
Subtotal	**7,152**	**12.8**	**8,956**	**16.0**	**16,108**	**28.8**	**39,894**	**71.2**	**56,002**	**100**
HealthAmerica[d]										
2/1/83-12/31/83	335	4 2	1,374	17 4	1,709	21 6	6,207	78 4	7,916	100
1/1/84-12/31/84	351	3 4	772	7 5	1,123	10 9	9,140	89 1	10,263	100
Subtotal	**686**	**3.8**	**2,146**	**11.8**	**2,832**	**15.6**	**15,347**	**84.4**	**18,179**	**100**
AV-MED[d]										
10/1/82-09/30/83	529	2 1	2,391	9 3	2,919[f]	11 3[f]	22,875	88 7	25,794	100
10/1/83 04/30/84	503	2 5	1,503	7 3	2,006	9 8	18,515	90 2	20,521	100
Subtotal	**1,032**	**2.2**	**3,894**	**8.4**	**4,925[f]**	**10.6**	**41,390**	**89.4**	**46,315**	**100**
Total	**$8,870**	**7.4**	**$14,996**	**12.4**	**$23,865[f]**	**19.8**	**$96,631**	**80.2**	**$120,496**	**100**

[a]According to the congressional request, these expenses were to be compared to revenues Comparing them to revenues distorts the results because the percentage of profit or loss, which would affect the figures, varies by HMO and by time period

[b]CAC officials could not provide expense information for their Medicare program only

[c]Includes marketing and advertising expenses

[d]At the time of our review, these were the only time periods for which information was readily available

[e]Does not include amounts spent on marketing or overhead by the providers that contract with the HMOs

[f]Does not add due to rounding

The three HMOs' commercial marketing costs overall were about 7 percent of total costs, compared with 6 percent for Medicare marketing, as table 7.2 shows. IMC's commercial marketing costs were about 13 percent, compared with 6 percent Medicare; AV-MED's about 2 percent, compared with 8 percent Medicare; and HealthAmerica spent about 4 percent under both lines of business.

CAC officials could not segregate their Medicare and non-Medicare costs. During 1982, 1983, and 1984, however, CAC spent about 4 to 5 percent on marketing, 20 to 39 percent on overhead, and 56 to 74 percent on patient care.

Marketing Techniques Varied

The Florida demonstration HMOs marketed their plans through advertising and presentations to large groups. Each HMO had a marketing staff that responded to telephone inquiries. The methods used to pay the

sales people varied but generally they were paid commissions based on the number of people enrolled.

Each HMO used a combination of newspaper, radio, and/or television ads. IMC also used billboards. The amount of advertising, however, varied. For example, in 1984, HealthAmerica ran one radio ad 26 times and a newspaper ad 8 times. On the other hand, in the same year, IMC ran television ads 3,843 times and newspaper ads 285 times and also had 10 billboards.

To attract Medicare members, an HMO's marketing staff would set up meetings with various senior citizen groups to explain the program, the ramifications of the "lock-in" provision, and how to enroll. The marketing personnel provided details on benefits and costs of the program and answered questions. Interested persons could enroll at the presentation or leave their names, addresses, and telephone numbers so that an HMO representative could contact them.

Marketing staffs included full- and part-time sales representatives who were paid salaries, salaries plus commissions, or commissions. For example, HealthAmerica's representatives were generally salaried with no commission. In contrast, IMC basically paid commissions. At both AV-MED and IMC, sales representatives received no commission unless the new member stayed enrolled for at least 3 months

The HMOs' marketing techniques have resulted in some controversies For example, as mentioned in chapter 2, in November 1982, CAC got into legal difficulties with the local medical society over its mass mailing of promotional material that HCFA considered misleading. In early 1984, the Palm Beach County Medical Society, in response to what it considered to be one-sided promotional advertising, initiated its own promotional activities to counteract CAC's media effort. When the House Select Committee on Aging held congressional hearings in July 1984 and April 1985, a number of witnesses expressed concern about the HMOs' marketing techniques. The complaints focused on overly aggressive marketing staffs and the publication of misleading advertisements.

Federal and State Guidance on HMO Marketing

During the demonstration, HCFA's guidance to HMOs on marketing activities took the form of (1) requiring prior approval of HMO marketing materials to identify incorrect or misleading information before it was used, and (2) issuing February 1984 policy guidelines outlining the "dos and don'ts" of marketing materials to help HMOs identify incorrect or

misleading information before it was used. In addition, the state of Florida provided some guidelines spelling out prohibited marketing materials.

In exercising its right to prior approval of the HMOs' brochures and advertising copy, HCFA refused to approve certain material. For example, HCFA would not allow use of pictures of federal buildings such as the U.S. Capitol (suggesting federal sponsorship). Nor would it approve statements (1) indicating that under the "lock-in" provision payment for emergency or urgently needed services was contingent on the beneficiary notifying the HMO within a specific time period, (2) only mentioning emergency services, although out-of-area urgently needed services also should have been included, (3) that a plan was "no cost" when in fact the beneficiaries had to pay for some benefits, or (4) that a plan was sponsored or backed by the U.S. Government or the U.S. Government was behind it.

In February 1984, HCFA gave the demonstration HMOs marketing and benefit policy guidelines, which included a list of items to be covered in all marketing brochures as well as types of statements to be avoided. The guidelines advised each HMO, among other things, to

- emphasize the "lock-in" provision and explain the two exceptions—emergency and urgently needed services—that did not require prior authorization,
- list items excluded from coverage,
- advise beneficiaries on the plan's and Medicare's grievance procedures,
- describe the HMO's procedure for changing primary care physicians,
- clearly describe all costs to the beneficiary, and
- avoid claims that all the health care a beneficiary would need would be provided (unless the plan offered long-term care)

From our discussions with HCFA officials, we believe HMOs that did not participate in the demonstration project and that came into Medicare after TEFRA was enacted may not have received this comprehensive policy guidance from HCFA.

Under Florida law, the state Department of Insurance can order an HMO to discontinue using advertisements that do not comply with state requirements. In February 1985, the state issued advertising guidelines that required all HMOs to

- include the most important limitations on benefits,

- show the name under which the HMO was licensed by the state, and
- discontinue any reference to "free" benefits in their advertising.

The latter was based on the rationale that there is no such thing as "free" benefits; someone must pay for them even if the enrollee does not.

After TEFRA, Federal Rules on Marketing Change

Federal requirements on marketing by HMOs to potential Medicare enrollees have changed markedly several times. Under TEFRA, prior approval by HCFA of HMOs' marketing materials was no longer required. Consequently, HCFA stopped requiring HMOs to submit such materials for approval. But the TEFRA regulations effective February 1, 1985, do give HMOs guidance on marketing and prohibited the following activities:

- discriminatory marketing practices, such as concentrating on a class of beneficiaries likely to have better health status than other classes,
- misleading or confusing practices, such as claiming that the HMO was recommended or endorsed by HCFA,
- offers of gifts or payments as inducement to enroll, and
- door-to-door solicitation of Medicare beneficiaries.

Also, risk-type HMOs must give potential Medicare enrollees adequate written descriptions of additional benefits or services or reductions in premiums, deductibles, or copayments that might pertain to their plans.

In our opinion, these general provisions are not as specific and comprehensive as the policy guidance developed by HCFA during the demonstrations, and providing more explicit guidance would be useful for reminding HMOs of the "dos and don'ts." Problems can occur. For example, in April and October 1985, IMC used newspaper ads that contained material that would have been prohibited earlier, e.g.:

- Its April ad featured a picture of the U.S. Capitol and the phrase "with the U.S. Government behind us."
- Its 24-page Sunday supplement in October included a picture of the U.S. Capitol and the statement that IMC had been awarded the classification of type B HMO from OHMO, saying this ". . . is the highest category of qualification an HMO can receive. Federal qualification is assurance to our members that the health plan meets high standards of medical care, management capability and financial stability." (Actually, a class B designation means an HMO has demonstrated sufficient financial soundness over a 3-year period to reduce its federal financial reporting

requirements from quarterly to annual reporting. It has no direct relation to quality of care or management capability.) The advertisement also stated that four hospitals were part of the IMC health care network, although IMC did not have contracts with the hospitals. The Florida Department of Insurance ordered IMC to place an advertisement stating it did not have contracts with these hospitals and fined IMC $5,000.

Another legislative change occurred under the Consolidated Omnibus Budget Reconciliation Act of 1985. This law requires TEFRA HMOs to submit marketing materials used on or after July 1, 1986, to HCFA for approval at least 45 days before issuance. The HMO can assume approval if HCFA does not respond within the 45-day period.

Conclusions

When we compared Medicare marketing costs with costs of selling to the commercial market at three of the Florida HMO demonstrations, we found the costs comparable for the periods analyzed. Medicare marketing represented about 6 percent of the total expenditures under their contracts, while marketing commercial lines of business cost about 7 percent of total expenditures.

Federal rules for HMO marketing efforts to enroll Medicare beneficiaries have varied with legislative changes. Under the HMO demonstrations, Medicare marketing materials required prior HCFA approval and, as part of the process, specific HCFA policy guidance emerged as to what material was considered appropriate or inappropriate. But this information was not passed on to the new HMOs under TEFRA.

Recommendation to the Secretary of HHS

We recommend that the Secretary require the HCFA Administrator to provide policy guidance to the TEFRA HMOs on marketing activities similar to the guidance furnished the demonstration HMOs in February 1984.

Agency Comments and Our Evaluation

HHS officials, in commenting on our draft report, did not take a position on this recommendation. They discussed their overall monitoring role and the requirement imposed by the Consolidated Omnibus Budget Reconciliation Act of 1985 to require TEFRA HMOs to submit (as under the former demonstration program) marketing materials for prior HCFA review. We continue to believe that HMOs can benefit from more explicit policy guidance similar to that formerly provided to the demonstration HMOs to help forestall some of the problems experienced with HMO marketing practices during the demonstrations

Use of HMO Mortality Rates to Adjust Payment Rates

In this appendix, we calculate the percentage of the AAPCC, based on observed HMO and regular Medicare survival rates, that would result in HMO payment rates costing Medicare no more than if the enrollees had remained in the fee-for-service market. Our computations are based on research data for 1978 published in 1984 by HCFA's Office of Research and Demonstrations on Medicare survival rates and the average annual Medicare costs for decedents and survivors. On average, 5.9 percent of Medicare enrollees 67 years or older died in 1978, and the Medicare costs of decedents in their last year of life were 6.2 times higher than the Medicare costs of those who survived. Through the algebraic formulas presented below, we use HMO actual mortality rates and HCFA's published 5.9 percent average mortality to calculate the adjustment necessary to HMO payment rates to achieve 5-percent Medicare program savings, given the lower mortality and lower associated medical costs of HMO enrollees.

Our results are dependent upon (1) the accuracy of HCFA's 1978 statistics and (2) the assumption that the ratio of Medicare costs for survivors and decedents calculated for 1978 remains approximately the same today. Although we did not verify the HCFA statistics, we did review other research addressing the issue of Medicare costs by mortality class. In our view, the data used are the most appropriate currently available.

In step 1, a formula for average reimbursement is developed and used to estimate Medicare average reimbursement in 1978. In step 2, the average reimbursement formula is modified to account for HMO payments at .95 of the AAPCC and used to calculate an HMO mortality rate below which the risk-HMOs would cost more than fee-for-service. In step 3, the impact of low HMO enrollment by the institutionalized and Medicaid-eligible on the observed .6559 ratio of actual to expected mortality (from p. 63) is estimated. In step 4, the average reimbursement formula of step 2 is used to calculate the percentage of AAPCC, currently established by statute at .95, that, based on observed mortality rates, would lead to the risk HMOs costing neither more nor less than regular Medicare.

- Step 1. The average reimbursement rate, a weighted average of reimbursement for decedents and reimbursement for survivors, is calculated as follows:

Average reimbursement = (mortality rate x average reimbursement for decedents) + (survival rate x average reimbursement for survivors)

All four of these values estimated for 1978 are available in an article by Lubitz and Prihoda published in 1984.[1]

(1) Average reimbursement = (.059 x $4,527) + (.941 x $729)
= $953.08 in 1978

- Step 2. The HMO mortality rate for those aged 67 and older below which higher implicit cost in the non-HMO sector would offset the 5-percent AAPCC savings is calculated as follows:

  Let X be the HMO mortality rate.

  (2) .95 x 953.08 = X x 4,527 + (1-X)729
  X = .046

  If HMOs select and retain Medicare beneficiaries aged 67 and older who will die within 1 year at a rate less than 4.6 percent, the biased selection/retention loss to the government will outweigh the "savings" from paying 95 percent of the AAPCC (all other things being equal or counterbalancing).

- Step 3. In this step, we estimate the impact of low HMO enrollment by the institutionalized and Medicaid-eligible on the .6559 ratio of actual to expected mortality computed for the 27 risk-based HMOs. Institutionalized and Medicaid-eligible beneficiaries have higher mortality rates than noninstitutionalized or non-Medicaid-eligible beneficiaries. Further, the 27 risk-based HMOs that we studied enrolled relatively few institutionalized or Medicaid-eligible beneficiaries, which may account for at least

[1]See J Lubitz and R Prihoda, "The Use and Cost of Medicare Services in the Last 2 Years of Life," Health Care Financing Review, Vol 5, No 3, Spring 1984, pp 117-131. The Lubitz and Prihoda study is based on a 5-percent sample of Medicare enrollees in 1978 The study is limited to enrollees 65 years of age or over, disabled enrollees under 65 years are excluded Further, Medicare reimbursement statistics by survival status are presented only for those 67 years of age or older The average reimbursement value of $953 08 for those 67 years and older is approximately 3 percent higher than the average 1978 reimbursement value of $922 22 implied by total Medicare program expenditures of $24 9 billion for 27 million Medicare enrollees, 90 percent of whom were aged 65 or older See R Gibson, "National Health Expenditures, 1978," Health Care Financing Review, Vol 1, No 1, Summer 1979, p 9

some of the phenomenon of actual mortality being lower than the age- and sex-adjusted mortality. Because our actuarially estimated mortality rates were adjusted for age and sex only, an enrollment adjustment factor must be developed.

Thus, we computed the ratio of the weighted average Medicare mortality across three classes of beneficiaries to the weighted average risk-based HMO mortality across the same three classes. When developing this enrollment adjustment factor, we assumed that HMO and Medicare mortality rates were equal within each class of beneficiary. The three classes were (1) Medicaid-eligible, (2) institutionalized and non-Medicaid, and (3) noninstitutionalized and non-Medicaid.

Table I.1, with X representing the mortality of the noninstitutionalized and non-Medicaid beneficiaries, summarizes the data we used. Note that in table I.1, one additional class of beneficiary is introduced—the institutionalized. The institutionalized are included in the Medicaid and institutionalized non-Medicaid class in the analysis presented in this appendix.

Table I.1: Medicare and HMO Enrollment and Mortality Data by Class of Beneficiary Used in Subsequent Calculations

Class of beneficiary	Enrollment (percent) Medicare population	Enrollment (percent) 27 risk HMOs	Mortality
Institutionalized	4 8[a]	0 196[b]	316[c]
Medicaid-eligible	9 94[d]	3 63[e]	0 01 + 1 468X[f]
Institutionalized, non-Medicaid	1 9[g] (4 8 x 4)	0 169[h]	316[i]
Noninstitutionalized and non-Medicaid	88 16[j]	96 20[k]	X
All Medicare aged beneficiaries	•	•	0458742[l]

[a]National Nursing Home Survey 1977 Summary for the United States, National Center for Health Statistics, Ser 13, No 43, July 1979, table 18, p 28 The 4 8 percent is for the general population aged 65 and older

[b]GAO-computed percentage of May 1984 HMO Medicare enrollees in 27 risk-based HMOs who were institutionalized

[c]Institutionalized mortality rates are based on the ratio of nursing home residents aged 65 and older discharged dead and known deaths among live nursing home discharges to other facilities (Discharges From Nursing Homes 1977 National Nursing Home Survey, National Center for Health Statistics, Ser 13, No 54, Aug 1981, table N, p 13) to the total number of nursing home residents aged 65 and older (from same source as footnote a, table 19)

[d]HCFA, Office of the Actuary, Division of Medicare Cost Estimates, interview, March 26, 1986

[e]GAO-computed percentage of May 1984 Medicare HMO enrollees in 27 risk-based HMOs who were eligible for Medicaid

[f]Mortality rates for aged persons entitled to both Medicare and Medicaid are for 1978 and are age-adjusted (from A McMillan, et al , "A Study of the 'Crossover Population' Aged Persons Entitled to Both Medicare and Medicaid," Health Care Financing Review, Summer 1983, Vol 4, No 4, table 13, p 35) The mortality is 1 5 times the non-Medicaid mortality rate, a weighted average of institutionalized, non Medicaid and noninstitutionalized, non-Medicaid mortality rates, computed as follows

$$\frac{1\ 5\ (1\ 9 \times\ 316 + 88\ 16X)}{1\ 9 + 88\ 16} = 01 + 1\ 468X$$

[g]National Nursing Home Survey data for 1977 indicate that, for the 1 3 million individuals in nursing homes, Medicaid supported in whole or in part between 48 and 75 percent of these residents Based on these statistics, we have used 60 as the percentage of the institutionalized Medicare population that is Medicaid eligible

[h]GAO-computed percentage of May 1984 Medicare HMO enrollees in 27 risk-based HMOs who were institutionalized but not eligible for Medicaid

[i]Assumed to equal the rate for the institutionalized

[j]Calculated by subtraction, 100 - 9 94 - 1 9

[k]Calculated by subtraction, 100 - 3 63 - 169

[l]J Wilkin, "Recent Trends in the Mortality of the Aged," Transactions, Vol XXXIII, 1981, table 2, presents a 1978 mortality rate of 0 051147 for all Medicare aged beneficiaries We used the 1 9-percent annual improvement in mortality over the 1968-78 period also reported by Wilkin to project the 1978 rate to 1984 The rate of 0 045742 for 1984 listed in table I 1 was the result

The enrollment correction factor to adjust for institutionalization and Medicaid eligibility is calculated as follows:

For the general Medicare population, Medicare average mortality is the weighted average of 3 mortality rates from table I.1, using table I.1 Medicare population enrollment as weights.

$$\text{(3) Medicare average mortality} = .8816X + (.019 \times .316) + .0994\,(.01 + 1.468X) = 1.0275X + .006998$$

For the HMO population, HMO average mortality is the weighted average of 3 mortality rates from table I.1, using table I.1 HMO enrollment as weights.

$$\text{(4) HMO average mortality} = .9620X + (.00169 \times .316) + .0363\,(.01 + 1.468X) = 1.01529X + .000897$$

Therefore, the enrollment adjustment factor, the ratio of Medicare average mortality to HMO average mortality, is

$$\text{(5)}\ \frac{1.02752X + .006998}{1.01529X + .000897}$$

But one can calculate the 1984 value of X, the mortality rate of the noninstitutionalized and non-Medicaid Medicare beneficiaries, as follows, using 1984 Medicare average mortality of .0458742 from table I.1:

$$.0458742 = .8816X + (.019 \times .316) + .0994\,(.01 + 1.468X)$$
$$1.028X = .0389$$
$$X = .0378$$

A 1984 mortality rate was used because the enrollment adjustment factor will be used to adjust our 1984 calculated ratio of actual to actuarially projected mortality.

Substituting X = .0378 into equation 5 yields

$$\text{(5)}\ \frac{.038884 + .006998}{.038378 + .000897} = \frac{.045882}{.039275} = 1.168$$

The enrollment-adjusted ratio of actual to actuarially projected mortality is

(6) 1.168 x .6559 = .7661

Restated, this suggests that the institutional/Medicaid composition of the risk-based HMOs' enrollment has resulted in an understatement of adjusted HMO mortality of about 11 percent (76.61 - 65.59 percent). If these HMOs had a mix of enrollees with the same proportion of institutionalized and Medicaid as the Medicare program overall, the ratio of actual to expected mortality would have been .77 rather than the .66 observed.

- Step 4. The reimbursement percentage, presently set at .95, that would lead to actuarial equivalence, given the .7661 ratio of actual to expected survival rates for the 27 risk-based HMOs, is calculated as follows.

Given that in step 3 we found an HMO risk-based mortality rate of .7661 of the actuarially predicted level, after adjusting for low Medicaid and institutionalized enrollment in step 3, on average instead of 5.9 percent mortality rates, the calculated risk-based mortality rate is .7661 times 5.9 percent or 4.520 percent . Let Y be the reimbursement percentage. Substituting into equation (2) and solving for Y yields

(7) $Y \times 953\ 08 = (.04520 \times 4{,}527) + 729 \times (1-.04520)$

$953.08Y = 900.67$

$Y = .9450$

If the program were to pay 94.50 percent of the AAPCC or more, given the selection bias as indicated by survivor rates, the program will cost more than if the risk HMO program did not exist. If observed survival rates were to continue, then, if the program is to save 5 percent of AAPCC, .9450 minus .05 or .8950 of the AAPCC should be paid.

We considered three other studies as sources of data for this appendix. But one was limited to results from the state of Colorado only[2] and the other two to reimbursement data for decedents for 1 calendar year,

[2]N McCall, "Utilization and Costs of Medicare Services by Beneficiaries in Their Last Year of Life," Medical Care, Vol 22, No 4, Apr 1984, pp 329-342

rather than 12 full months preceding death.[3],[4] The latter is a severe limitation in a survival study because decedents will be enrolled for an average of only 6 months while survivors will have a full 12 months of exposure.

The Lubitz and Prihoda study excluded Medicare beneficiaries aged 65 and 66, because the study required a full year of Medicare experience for analysis. Two additional pieces of information would be required to explicitly include 65- and 66-year-old beneficiaries: expenditure data by mortality status and mortality rates. Only the latter data, used in step 3 above, exist. The overall mortality rate of .059 would have declined to .051 if those 65 and 66 had been included. The Lubitz and Prihoda expenditure data suggest that there is a marked decline in the ratio of expenditures for decedents and survivors with increasing age (see p. 67). While they found an overall average ratio of 6.2, for beneficiaries aged 67-69 the ratio was 9.8, compared with a ratio of 3.7 for those 85 years and older. This suggests that the values of .9450 and .8950 are conservative estimates, and we believe that these adjustments would be largely offsetting. Consequently, although we could not adjust for this because of the lack of data, we have no reason to believe that our results would be materially changed.

[3]P Piro, and T. Lutins, "Utilization and Reimbursements Under Medicare for Persons Who Died in 1967 and 1968," Health Insurance Statistics, HI-51, Office of Research and Statistics, Social Security Administration, DHEW Pub No (SSA) 74-11702, Oct. 1973

[4]C Helbing, "Medicare Use and Reimbursement for Aged Persons by Survival Status, 1979," Health Care Financing Notes, Office of Research and Demonstrations, HCFA, HCFA Pub No 03166, Nov 1983.

HCFA Noncompliance Notification to IMC, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

The Administrator
Washington, D C 20201

May 30, 1986

Mr. Miguel Recarey, Jr.
President
International Medical Centers, Inc.
1505 N.W. 167th Street
Miami, Florida 33169

Dear Mr. Recarey:

This is to serve notice that pursuant to the provisions of Section 1312, Title XIII, Public Health Service Act (the Act), as amended, I have determined that International Medical Centers, Inc. (IMC), is not in compliance with the Act and applicable regulations. Specifically, IMC does not have administrative and managerial arrangements satisfactory to the Secretary as required by Section 1301(c)(1)(B) of the Act and does not have an acceptable ongoing quality assurance program for its health services as required by Section 1301(c)(7) of the Act.

The Office of Health Maintenance Organizations (OHMO) notified you by letter dated April 18, 1986, that it was expanding OHMO's April 4, 1986, evaluation of IMC's administrative and managerial arrangements and initiating an evaluation related to IMC's quality assurance program.

I. ADMINISTRATIVE AND MANAGERIAL ARRANGEMENTS

42 CFR 110.108(a)(2)(ii) requires a federally qualified health maintenance organization (HMO) to have personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the HMO. OHMO's determination of IMC's noncompliance in this area is supported by the following facts:

Health Services

IMC does not have the personnel and systems sufficient for IMC to organize, plan, control and evaluate the health services aspects of the HMO.

- IMC's arrangements for health services are not a system but rather approximately 200 affiliated provider centers which have little interface with IMC and may or may not have structured arrangements for referral specialists, which include physician specialists and ancillary health care providers (hereafter referred to as referral providers). The affiliated providers are categorized as: 1) IMC's wholly-owned centers which are owned and staffed by IMC; 2) centers for which IMC dictates the referral providers which must be used by these centers; and 3) those centers which operate independent of IMC control.

IMC has described its arrangements for health services as follows: IMC contracts with an affiliated provider. The affiliated provider must have written agreements with referral providers to provide services which are not available or accessible within that particular affiliated provider's center. IMC contracts with hospitals, skilled nursing facilities, and home health agencies. In some instances, IMC contracts directly with referral providers, hospital-based specialists, ambulance services, and other providers who make their services available to all affiliated providers in a given geographic region. The affiliated providers may refer their IMC patients to these providers if they so desire, or in some instances, must refer to these providers.

Under the structure described above, payments for inpatient hospital, skilled nursing facility, and home health agency charges, and reinsurance costs are paid through IMC's central administrative office and are charged against a separate account maintained in the name of each affiliated provider. The affiliated provider receives a capitation payment to cover the cost of the remaining services which an IMC member enrolled at that center may require under IMC's benefits package. The affiliated provider is responsible for reimbursing referral providers for rendering these services to IMC's members.

In practice, the problems associated with these arrangements for health services as they currently operate are:

1) IMC does not have accurate or current information on the affiliated providers' referral arrangements. Some contracts have been terminated and new contracts have been executed without IMC's knowledge. In some instances, there are no contracts in effect, only oral agreements. Some of the affiliated providers have stated that they are unwilling to share the names of their referral providers with IMC because they believe that IMC may negotiate directly with the specialists. If this occurred, the affiliated providers would lose part of their capitation payment, the portion designated for referral provider reimbursement. Since IMC has a history of late payments, the affiliated providers have reported that they fear that the referral providers will not be paid in a timely manner and eventually will stop rendering services to their patients. Without accurate information on the affiliated providers' referral provider arrangements, IMC does not know what referral provider services are available, accessible, or acceptable to IMC's members. Therefore, IMC is unable to demonstrate that its members will be able to receive the benefits to which they are entitled.

2) Another problem is the lack of information provided by IMC to affiliated providers, to individual physicians within the affiliated providers' centers, and to individual referral providers. There is virtually no regular or systematic feedback provided to physicians regarding utilization, cost, or quality of health care services rendered. Although an effort has been undertaken to design inpatient hospital utilization and cost data, this information is not regularly provided to the affiliated providers. Further,

the ambulatory encounter data provided by the affiliated provider to IMC is incomplete. Finally, comparative data among affiliated providers and data for individual physicians is not provided. IMC has the capability to produce computerized reports using such data, however, reports have only been distributed once. They were sent out to providers with a cover letter asking for comments and recommendations. When only one comment was received, IMC decided that, due to lack of interest on the part of its providers, the reports would no longer be sent out. Without this information, the affiliated providers cannot monitor and manage their own utilization and cost patterns.

3) Another concern is the lack of continuity of care. As an example, with some affiliated providers, the physicians who treat IMC members on an outpatient basis are not the same physicians who serve as attending physicians for inpatient hospital care. IMC members requiring inpatient hospital care are sometimes transferred to the care of physicians outside of the affiliated providers' control. The site visit team could find no evidence that there were any specific policies or procedures in place for the exchange of information to ensure that continuity of care is maintained for IMC members.

- At the March 1985 site visit, IMC stated that it was implementing an "Affiliated Provider College" which was intended to be a formalized training program to educate its affiliated providers about risk management, utilization control, quality assurance, etc. The most recent site visit team was informed by providers that there has only been one session held.

- Affiliated providers are not operating within a managed health care delivery system. Their relationship with IMC and data received from IMC are inadequate. Little attention is given to assisting the affiliated providers with their management either through information or staff resources. Affiliated providers manage themselves with little assistance or oversight from IMC.

General Management

IMC does not have the personnel and systems sufficient for IMC to organize, plan, control and evaluate the general administrative and management aspects of the HMO.

- IMC produces a computerized report (MMIS100R1 - Center Delivery System) which lists the referral providers for each of IMC's affiliated providers. This report should be a good management tool as it includes the provider's name, specialty, IMC provider number, medical license number and expiration date, Drug Enforcement Administration (DEA) license number and expiration date, and hospital affiliation(s). However, as stated earlier, some of the affiliated providers have reported that they do not give IMC their actual list of referral providers for fear that IMC will try to gain control over their business. Thus, the accuracy of the report itself is questionable. In addition, a copy of the report (run on April 29, 1986) shown to the site visit team, showed numerous

entries for medical licenses and DEA licenses which had expired in 1985. At best, one could conclude that the information is not being updated in a timely manner. If this is the case, the report is not useful. As stated previously, without accurate information on the affiliated provider referral arrangements, IMC is unable to assure that referral provider services are available, accessible, or acceptable to IMC's members.

- The collection of ambulatory data is dependent upon the submission of Encounter Forms by affiliated providers, the receipt of External Referral Forms from referral providers, and IMC claims payment activity. The accuracy of the data is dependent upon the completion and submission of the forms by the affiliated providers. There has been no known validation of data performed by IMC management to ensure this information is accurate. Furthermore, the site visit team was told by IMC staff that there is only a 50 percent compliance rate regarding the completion of encounter data by the affiliated providers.

- IMC does not process provider claims on a timely basis. This could be the reason why over 60 percent of IMC's current complaints and grievances relate to claims. For example, as of March 25, 1986, 53 percent of IMC's claims payable were over 90 days old with an additional 34 percent, over 60 days old. IMC had no organized approach to address this problem. IMC has a computer-assisted claims processing system. IMC uses its computer system only to check on very basic information such as member's date of eligibility, whether or not the provider is an authorized provider, and if there is a referral authorization on file. Claims adjudication for the most part is left up to 45-60 claims processors to handle on a manual basis. For an HMO with 200,000 members, this is not an acceptable administrative arrangement.

- Although the affiliated provider is responsible for paying referral providers for services rendered to IMC members, there are occasions when a referral provider or member sends a bill to IMC because the affiliated provider has not paid the referral provider for services rendered. IMC may intercede and pay the outstanding bill, which is the responsibility of the affiliated provider, and will deduct the amount from the affiliated provider's next capitation check. When affiliated providers receive their monthly capitation checks from IMC, there is insufficient information provided with the check to enable the providers to determine if bills were paid properly on their behalf.

- IMC does not have effective complaint and grievance procedures as evidenced by the volume of complaints which have been received by OHMO, the Health Care Financing Administration, the Florida Department of Insurance, and several congressional offices. The site visit team found evidence that IMC's members were not given copies of the grievance procedures to be followed in filing a complaint either as part of the initial information package given to them upon joining IMC or at a later date. This is not a satisfactory administrative arrangement.

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II. QUALITY ASSURANCE PROGRAM

42 CFR 110.108(h) requires a federally qualified HMO to have an ongoing quality assurance program which stresses health outcomes to the extent consistent with the state of the art; provides review by physicians and other health professionals of the process followed in the provision of health services; uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change; and includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

The determination of noncompliance relating to IMC's quality assurance program is based upon a review of IMC's systems during the OHMO site visit of April 28 -May 2, 1986, to IMC's administrative offices in Miami and Tampa as well as upon provider interviews throughout IMC's federally qualified service area. In the course of its review, OHMO has taken into consideration IMC's lack of progress in implementing certain internal systems relating to quality assurance which, OHMO was told during the March 1985 site visit, were to be operational by now. The following facts support OHMO's determination of noncompliance:

o IMC does not have satisfactory organizational arrangements to ensure an ongoing quality assurance program. IMC has a Quality Assurance Committee; however, it consists only of IMC's corporate staff, which includes the Regional Medical Directors. There is no participation on the committee by IMC's physician affiliated providers, consulting specialists or non-physician health care providers. The site visit team found no evidence that the corporate Quality Assurance Committee had been charged by the the Board of Directors of IMC with carrying out the quality assurance activities. Although IMC does have a quality assurance plan, there is no evidence that it has been shared with IMC's affiliated providers. Further, there is a lack of active participation by providers of medical care as confirmed in conversations with physicians interviewed during the April 1986 site visit. Some had not heard of IMC's quality assurance activities.

  IMC's regional quality assurance structure has failed. When OHMO reviewed IMC's quality assurance program in March 1985, regional quality assurance committees had been established and were chaired by the Regional Medical Directors. Participants on these committees were to include the medical directors of the affiliated providers within each region. In March 1985, IMC indicated that it was planning on changing the structure of these Regional Committees so that each committee would consist of three affiliated provider medical directors, three surgeons, and three other providers. It was proposed that regional quality assurance meetings would be held every other month. There was no evidence of these regional meetings being held routinely. The site visit team was told by IMC's Directors for Quality Assurance during the recent site visit that the regional quality assurance committee structure has been abandoned.

Page 6 - Mr. Miguel Recarey, Jr.

- IMC's quality assurance activities are divided into three "phases." Phase I is an external facility review of each affiliated provider center. The review is conducted by a 3-person team from the appropriate IMC regional office and typically includes a nurse, a physician, and an administrator. This review focuses on confirmation of physician credentials; process issues such as waiting times; structure issues relating to the condition and accessibility of equipment; and a chart review which emphasizes the condition, completeness, and legibility of the chart.

  Phase II refers to internal peer review through review of charts using specified, clinically valid criteria on a particular topic, with center physicians reviewing the charts of their peers.

  Phase III is an inpatient concurrent chart review process conducted by the utilization review coordinators. A Phase III review would be initiated when certain "negative outcomes" are identified (such as a transfer to an intensive care unit during the course of a hospitalization or an unplanned return to the operating room during the same admission).

  Phase I activities are ineffective because:

  1) centers are notified of the audit several weeks in advance;

  2) centers are told in advance of the kinds of deficiencies which will be examined (e.g., expired medications, malfunctioning fire extinguishers); and

  3) centers are allowed to select their own charts for the chart reviews.

  The weakness of Phase II activities is a lack of participation by the providers of care in the study process. For example, the practicing physicians are not involved in identifying problem areas, determining the study topics, developing the clinically valid criteria, or analyzing data and interpreting results.

  Phase III activities have major weaknesses in that:

  1) Some of the affiliated providers were not aware of the fact the inpatient concurrent review for negative outcomes was taking place. Feedback regarding identified problems is not provided to the affiliated providers.

  2) Much of the inpatient care received by IMC members is not subject to Phase III activity. IMC review coordinators review medical records only at hospitals with which IMC contracts; a significant portion of inpatient care is delivered at non-contracting hospitals.

- IMC does not have adequate and accurate data, as described in the "General Management" discussion above, and does not include systematic data collection as a major component in its quality assurance plan.

Page 7 - Mr. Miguel Recarey, Jr.

Pursuant to the provisions of Section 1312(b)(1) of the Act and implementing regulations at 42 CFR 110.904(c)(2), you are hereby directed to submit, within 30 days of the date of this letter, a proposed time-phased corrective action plan (CAP) to address the deficiencies described above as a means of restoring compliance with Section 1301(c)(1)(B) and 1301(c)(7) of the Act. The proposed CAP must be set forth in narrative form and describe in sufficient detail the items discussed above, and minimally must address those listed below, as well as all other pertinent information. Each item shall include a timetable for implementation, as appropriate.

1. Develop and implement an ongoing communication system to manage IMC's health care delivery system and to assure effective exchange of information with its affiliated providers so that the affiliated providers can monitor and manage their utilization and cost patterns. It should include provisions for exchange of data, feedback to providers and management, and appropriate resources to enable the affiliated providers to interpret information received.

2. Develop and implement procedures and policies to assure continuity of care for IMC's members.

3. Demonstrate that IMC is maintaining current information on its health services delivery arrangements on an ongoing basis to assure the availability, accessibility, and acceptability of health care.

4. Demonstrate that IMC's claims payment process and that of its affiliated providers are paying provider claims on a timely basis so that members will not be billed for covered services.

5. Demonstrate that the grievance procedure has been or will be distributed to IMC's current members and that all new members will receive a copy at the time of enrollment.

6. Demonstrate that multiple sources of data, including encounter data, referral data, complaints and grievances, are being used to assess performance and patient results and that interpretation of these data are provided to IMC's practitioners.

7. Demonstrate that IMC's quality assurance program has been modified to include the active participation, in all aspects of quality assurance activities, by physician and non-physician providers who treat IMC's members.

After I receive your proposed CAP, I will notify you either that I approve your proposed plan and timetable for implementation, or if the CAP is not satisfactory or if no CAP is submitted within 30 days of the date of this notice, I will prescribe such action, along with an implementation schedule, as is necessary in my judgment to bring IMC into compliance with its assurances.

IMC must then initiate the corrective action as prescribed in the notice approving the proposed CAP or in the notice prescribing the necessary corrective action. Failure of IMC to do so within 30 days of the issuance of the notice may result in the revocation of qualification of IMC under the provisions of Section 1312(b)(1) of the Act and 42 CFR 110.904(d).

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The CAP and all related materials should be mailed, in duplicate, to:

Director, Office of Health Maintenance Organizations
Attention: Ms. Sharley L. Chen
Room 9-11, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

If you have any questions regarding this letter, please contact your compliance officer, Ms. Chen, at (301) 443-4943.

Sincerely,

William L. Roper

William L. Roper, M.D.
Administrator

cc: Florida Department of Insurance

Analysis of Part B Services by Top Five Providers to HMO Enrollees 1 Month Before Effective Date of Enrollment (Three Florida HMOs)

In this appendix, we discuss our analysis of part B services provided to HMO enrollees during the month preceding their effective enrollment dates from the five providers generating the most allowed charges for each of three Florida HMOs (CAC, IMC, and AV-MED).[1] Following is a discussion of our overall methodology and the results for the three HMOs.

For each HMO, we used Florida Blue Shield's part B payment history files for the period October 1982-June 1984 to determine the five providers generating the most allowed charges for each HMO's enrollees during the month immediately preceding their effective date of enrollment. For each provider, we determined by HMO the number of enrollees receiving part B services, the total allowed charges, and whether the provider was affiliated with the HMO. Using a 2-percent random sample of all HMO enrollees receiving a part B service 1 month prior to enrollment, we determined whether (1) the enrollee was an established patient (e.g., seen by the physician before) or a new patient for the billing provider and (2) the type of service provided. We distinguished between new and established patients because we believe there is less likelihood of "screening" with established patients; presumably the physicians would know their health status without a preenrollment examination.

Services to CAC Enrollees Before Enrollment

For new CAC enrollees, the five providers generating the highest aggregate allowed charges for services provided within 1 month prior to the effective date of enrollment are listed in table III.1. In addition, the table presents the number of enrollees receiving services from each of the five providers and the total allowed charges for the services.

[1] As discussed on p 72, we have excluded HealthAmerica from this analysis because our review of the top five providers of services to their preenrollees showed the providers had no apparent affiliation with the HMO

Table III.1: Identification of Five Providers Generating the Most Allowed Charges to CAC Enrollees in Month Prior to Effective Date of Enrollment

Provider and affiliation with HMO	No. of enrollees billed	Total allowed charges
CAC	2,148	$161,396
Private physician[a]	75	14,924
Unidentified[a]	98	8,395
Group specializing in digestive diseases[a]	9	6,326
Private physician[a]	2	4,170
Subtotal	**b**	**$195,211**
Total matches (see table 4.9)	**2,852**	**$428,228**
Top five providers as percent of total allowed charges	•	**46**

[a]No apparent affiliation with CAC

[b]Because enrollees can be served by more than one provider, numbers should not be added

To assess the likelihood of potential screening, we obtained and analyzed more detailed claims data regarding the types and places of service for a random sample of 48 of the 2,148 beneficiaries seen by CAC doctors before their effective enrollment dates. For all 48 beneficiaries, CAC doctors had billed for services provided in their offices. For 44 of the 48 new enrollees, the services involved office visits for established patients plus certain laboratory tests and occasional X-rays and EKGs. For three of the four remaining beneficiaries, the services involved office visits for new patients plus certain laboratory work and one EKG. For the last beneficiary, the services involved an X-ray.

Because all 48 beneficiaries became members of the HMO, and we identified most as established patients of CAC doctors, we cannot conclude that CAC was engaged in screening new enrollees to obtain information on their health status or to supplement their capitation payments by setting up medical records and charging the costs to the fee-for-service system. It is clear, however, that CAC did have current information on the health status of about 41 percent of its Medicare members before the effective dates of their enrollment in the HMO. Thus, the potential for screening seems significant and should not be disregarded.

Services to IMC Enrollees Before Enrollment

Summary statistics from our analysis of detailed claims data for the five providers that generated the most allowed charges billed for a sample of new IMC enrollees are presented in table III.2.

Table III.2: Identification of Five Providers Generating the Most Allowed Charges to IMC Enrollees in Month Prior to Effective Date of Enrollment

Provider and affiliation with HMO	No. of enrollees billed	Total allowed charges
IMC-owned clinics	1,387	$182,295
Affiliated provider no 45 and four of its physicians	[a]	166,818
Independent laboratory[b]	2,390	101,611
Diagnostic imaging firm[c]	237	98,859
Affiliated provider no 28	479	57,184
Subtotal	[d]	**$606,771**
Total matches (see table 4 9)	19,862	$3,652,007
Top five providers as a percent of total allowed charges	•	17

[a]The total number of beneficiaries associated with the five providers using this center was 1,781, however, because the doctors worked at more than one center and one beneficiary could be billed by more than one provider, this total is overstated

[b]The laboratory's services included referrals from affiliated provider no 45

[c]This firm's services principally involved referrals from affiliated provider no 45

[d]Because enrollees can be seen by more than one provider, numbers should not be added

In contrast to CAC, the top five providers of services to IMC enrollees 1 month prior to their effective dates of enrollment provided most of the services to new patients. Overall, the services to "new" patients—typically involving an office visit, laboratory tests, an EKG, and/or an X-ray—were consistent with the services involved in setting up a medical record and charging the cost to Medicare fee-for-service instead of assuming the costs under their capitation rates after enrollment became effective.

IMC's two affiliated providers among the top five, centers no. 45 and no. 28 (IMC's designations), were the billing providers for services to a large percentage of their new enrollees during the month immediately preceding their effective enrollment dates. This suggests that the centers may have been systematically engaged in either screening applicants or supplementing revenues by establishing medical records prior to enrollees' effective enrollment dates.

Additionally, one of the top five providers to IMC enrollees prior to their effective dates of enrollment was providing diagnostic imaging procedures to a large number of enrollees. These are noninvasive procedures using sound wave imaging devices to detect vascular disorders. The provider delivered these services to 237 beneficiaries in the month preceding their effective dates of enrollment. Because this provider was not an IMC affiliate and the service was not frequently provided to other

beneficiaries in the HMOs we reviewed, we looked at each of these services in detail to determine why so many services were provided to IMC enrollees prior to enrollment.

The following sections summarize our findings at the three IMC providers—the IMC clinics and centers no. 45 and no. 28—and their referral patterns to the remaining two providers not formally affiliated with IMC (the independent laboratory and the diagnostic imaging provider).

IMC-Owned Clinics

The detailed claims data for a sample of 16 new enrollees where IMC was the billing provider showed that (1) for 9 enrollees, the services billed involved office visits or consultation for new patients, (2) for 6, the services billed involved "established" patients, and (3) for the remaining beneficiary, the status could not be determined from the claims data. Typically, the services billed and allowed for new patients involved an office visit or consultation plus laboratory tests, an EKG, and/or an X-ray, but the amounts allowed for established patients involved office visits and laboratory tests.

We matched a large number (80,186) of new IMC enrollees against Blue Shield payment history data of which only about 10 percent may have been assigned to the IMC clinics. Thus, we cannot conclude that billing by the IMC clinics for services to 1,387 enrollees in the month immediately preceding their effective enrollment constitutes credible evidence of systematic screening. The types of service billed for new patients, however, were consistent with the services involved in setting up a basic medical record for new HMO enrollees.

Affiliated Provider (Center) No. 45, Independent Laboratory, and Diagnostic Imaging Firm

IMC center no. 45 is an affiliated provider in Fort Lauderdale in Broward County. The detailed claims data for a sample of 31 new enrollees for whom the center or four of its physicians was the billing provider showed that 27 enrollees were new patients and the services billed involved office visits and laboratory tests for all 27 plus additional services, such as EKGs, for some. The services billed for the remaining four enrollees involved established patients where the service was generally limited to an office visit. The services billed and allowed for the 27 new patients during the month preceding their effective enrollment dates in IMC are summarized in table III.3.

Table III.3: Services Billed and Allowed for 27 New IMC Enrollees in Month Prior to Effective Date of Enrollment

Type of service	No. of new enrollees billed for
Office visit (new patient)	27
Laboratory test	27
EKG	15
X-ray	6
Diagnostic imaging procedure	9[a]
Follow-up office visit or consultation during same month	14

[a]Generally these services involved several noninvasive peripheral vascular diagnostic studies costing Medicare about $150 each and aimed at identifying blood circulation problems in an individual's extremities such as the legs and feet

For the 27 beneficiaries, the amounts Medicare allowed under the fee-for-service system averaged about $294. In all 27 cases, the laboratory services were billed by an independent laboratory (see table III.2). Most of the allowed charges, however, involved the diagnostic imaging services provided to 9 of the 27 new IMC enrollees. Therefore, we developed a detailed claims history for the 237 new Medicare enrollees shown in table III.2 who had obtained such services in the month immediately preceding their effective enrollment dates in IMC. The services were provided from July 1983 to February 1984, and the total charges allowed by Blue Shield were about $99,000.

Our analysis of the detailed claims data for the 237 new IMC enrollees who received diagnosis imaging services showed that

- where a corresponding physician's office visit was billed, center no. 45 or one of its four physicians had been the billing physician in all such cases, and these visits involved new patients 97 percent of the time;
- where laboratory services were also billed, the same independent laboratory (see table III.2) was the billing provider in all such cases;
- one physician was shown as the physician who performed the diagnostic imaging services in all 237 cases;
- all 237 beneficiaries had the same diagnoses (circulation disease); and
- in 46 of the 237 cases, a husband and wife received the same service on the same day.

We discussed the frequency of these services with one of the center's owners and were told that the four physicians also worked at another IMC-affiliated center where he had an interest, so that all the diagnostic imaging services may not have been performed at center no. 45. He also

mentioned that (1) the procedures involved a mobile unit and were performed on site at the center but the physician's interpretations were done elsewhere, and (2) the imaging firm paid the center a fee for the use of its facilities.

We also asked IMC for information as to how often comparable diagnostic imaging services were provided to the center's members under its risk contract where the center had to pay for the services. We identified two such cases from January 1984 through August 1985 as compared with the 237 new enrollees, for whom the costs of the diagnostic imaging services were charged to and paid by the regular Medicare fee-for-service program.

In view of the unusual nature of these utilization patterns and the fact that center no. 45 had a total enrollment of about 2,150 Medicare beneficiaries as of July 1984, we asked Florida Blue Shield to review the medical necessity of as many of the 237 cases it deemed appropriate and to develop information for all Medicare claims paid to the diagnostic imaging firm during 1984. According to a Blue Shield representative, its preliminary review of claims data for the new IMC enrollees shows a fairly clear and consistent pattern of patient screening. We have also referred the results of our review and Blue Shield's to the HHS Inspector General for investigation.

Affiliated Provider (Center No. 28)

IMC center no. 28 is also an affiliated provider located in Fort Lauderdale. The detailed claims data for a sample of 9 of the 479 new IMC enrollees where the center was the billing provider for services provided during the month immediately preceding their effective enrollment dates showed that the services for all 9 involved office visits for new patients. Six of the nine also received various combinations of diagnostic procedures such as laboratory tests, EKGs, and X-rays. The dates of service for four of the nine new enrollees were within 8 days of their effective enrollment dates in IMC and involved a series of diagnostic services. For example, for one new enrollee with an effective enrollment date of February 1, 1984, the regular Medicare fee-for-service system allowed charges for services provided on January 23, 1984, for an office visit to a new patient, various laboratory tests, an EKG, and an X-ray.

Because center no. 28 had about 1,700 Medicare enrollees as of July 1984, we believe that the fact that it was the billing provider for 479 new enrollees during the month immediately preceding their effective enrollment dates suggests that the center was either engaged in

screening or systematically setting up its Medicare records for new enrollees and charging the costs to the regular Medicare fee-for-service program.

Services to AV-MED Enrollees Before Enrollment

Analyzing the detailed claims data for a sample of nine AV-MED enrollees, we found a combination of several places and types of service (hospital and office, and new and established patients) as table III.4 shows No patterns emerged. For three of the nine cases involving new patients, however, the dates of service immediately preceded the effective enrollment dates, and the type of services included a wide range of diagnostic procedures that were consistent with setting up medical records for new patients.

Table III.4: Identification of Five Providers Generating the Most Allowed Charges to AV-MED Enrollees in Month Prior to Effective Date of Enrollment

Provider and affiliation with HMO	No. of enrollees served	Total allowed charges
Participating physician	84	$29,373
Participating group	[a]	24,720
Participating physician	106	9,089
Nonparticipating physician	1	5,308
Nonparticipating physician	3	4,490
Total	[a]	**$72,980**
Total matches (table 4.9)	**2,434**	**$404,274**
Top five providers as a percent of total allowed charges	•	**18**

[a]Because beneficiaries may have been seen by more than one provider, numbers should not be added

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington D C 20201

JUN 20 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Medicare: Issues Raised by Florida Health
Maintenance Organization Demonstrations"

Overview

GAO's review focused on four south Florida health maintenance organizations (HMOs) and was conducted in response to a request from Representative Smith and other members of the Florida congressional delegation. The report assesses the results of HHS' HMO risk-based demonstration projects by reviewing HHS' mechanisms for HMO oversight activities; the effectiveness of Federal standards for financial solvency and enrollment; the HMOs' marketing practices and costs and grievance procedures; and, Medicare savings from capitation. The four HMOs were: International Medical Centers, Inc. (IMC); HealthAmerica; Comprehensive American Care, Inc. (CAC); and, AV-MED.

GAO reports that beneficiary protections relative to HMOs' financial solvency and enrollment were substantially limited in network-type HMOs. According to GAO, such HMOs deliver many of their medical services through subcontractors, e.g., clinics and physician groups. Although these subcontractors assumed most of the HMOs' financial risk, legislative safeguards did not apply to them and they received little Federal or State oversight. In addition, and according to GAO, Medicare's payment methodology resulted in excessive reimbursement to the HMOs because it did not adjust payment rates on the basis of enrollees' health status. Reimbursement was based on average Medicare costs; but, GAO reports that HMO enrollees were healthier than the average beneficiary as measured by mortality rates. As a result, GAO concludes that they would generally need less medical care and cost the HMOs less overall; the effect of which is likely to increase Medicare costs rather than reduce them as intended. GAO also found that none of the four Florida HMOs was fully complying with Federal requirements to inform Medicare enrollees of their rights to grieve and appeal denied claims or services. According to GAO, the volume of complaints and the newness of the HMO system to Medicare beneficiaries suggest that such information is important.

GAO's recommendations and the Department's comments on those recommendations and related conclusions are discussed in detail below. We would note, however, that GAO's presentation appears to mix pre and post Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) oversight and activities of the HMOs. As a result, the findings of several alleged improprieties attributable to these organizations would not be experienced after the new TEFRA regulations were issued. In addition, the report does not recognize that these organizations did not have the same restrictions and operating rules as demonstrated under TEFRA, which could have substantially influenced overall findings on the cost effectiveness of these organizations. We do not believe that an accurate measure of the cost effectiveness of these projects could be properly measured based on total enrollment experience in these HMOs.

GAO Recommendations

That the Secretary direct the Administrator of the Health Care Financing Administration (HCFA) to (1) assure that IMC is making reasonable progress in meeting the 50-50 composition of enrollment standard or take enforcement action if IMC is not making such progress; and (2) develop an HMO timeliness of payment standard either through regulations or by including it as a standard item in all Medicare HMO contracts.

Department Comment

HCFA is monitoring this situation very closely. By way of background, when IMC initially entered HCFA's demonstration program, it applied for and received a waiver of the 50 percent Medicare and Medicaid membership limitation. This "waiver" was granted as part of its demonstration contract pursuant to 42 CFR 417.413(d)(2). In accordance with 42 CFR 417.413(e), if the plan was a demonstration project at the time it signed the contract, as was the case with IMC and two other plans, a waiver could be obtained providing the organization was making reasonable efforts to enroll non-Medicare/Medicaid beneficiaries. Since IMC met this regulatory criterion, HCFA granted it a waiver, which lasts for 3 years. The purpose of this type of waiver is to prevent any disruption in services already being provided to the Medicare beneficiaries participating in the demonstration.

HCFA has addressed this issue by monitoring IMC's progress in increasing commercial enrollment. In that regard, on February 25, 1986, HCFA wrote IMC a letter concerning IMC's need to comply with the 50 percent enrollment composition requirement. In addition, in carrying out this monitoring function, on March 24, 1986 HCFA requested IMC to submit within the next month its strategy for increasing the private, non-Medicare/Medicaid membership of its organization and reminded IMC that it will be necessary for HCFA to periodically monitor its efforts and progress in this area. On May 1, 1986, HCFA received an IMC letter dated April 24, 1986, which proposed the enrollment activities which would bring them into compliance with the 50/50 rule by 1988. After review, HCFA informed IMC by letters on May 13, 1986 and June 6, 1986 of the additional actions IMC needed to take. In response to the letters, IMC made a public announcement on June 12, 1986 indicating it would voluntarily cap Medicare enrollment at 137,500 until the end of 1986. Monitoring of IMC's marketing activities will continue on a monthly basis. In addition, HCFA has notified IMC of deficiencies in its administrative and managerial arrangements and quality assurance program. IMC must submit an acceptable time-phased corrective action plan by June 30, 1986, addressing these deficiencies, as a means of restoring compliance with Sections 1301(c)(1)(B) and 1301(c)(7) of the Public Health Service Act.

We are also taking positive management action to provide us with intermediate sanction authority. Short of terminating a contract with an HMO, there are currently no other intermediate level sanctions to provide incentives for an HMO to abide by its contract provisions. While termination may be a viable remedy in extreme cases, most contract infractions are not severe enough to warrant termination. In addition, termination may cause an undue hardship to the Medicare beneficiary enrolled in the HMO.

As to the second aspect of this recommendation, HCFA has developed a timeliness standard to be included in all Medicare HMO/Competitive Medical Plan (CMP) contracts. This standard, which parallels the payment standard that HCFA applies to its intermediaries and carriers, i.e., 85 percent of all bills must be processed within 30 days, will be included in all new contracts as well as those which will renew on or after July 1, 1986. To the extent that an HMO's inability to timely process its bills impacts upon the accessibility and availability of services provided to our beneficiaries, HCFA will become involved by enforcing this contract.

GAO Recommendation

HHS should issue regulations specifying standards for financial solvency and enrollment that an HMO must require of its risk-bearing subcontractors. At a minimum, the Secretary should require that an HMO contract with such risk-bearing affiliates provide the HMO with annual audited financial statements for its use in managing the affiliates and assessing its own financial condition. Furthermore, these data should be made available to HHS upon its request for use in making qualification and compliance determinations related to the financial status of the HMO and its affiliates.

Department Comment

All HMOs/CMPs are ultimately held responsible to pay for any health care claims provided through their plan and must assume full financial risk for providing such services based on the Medicare statute and regulations (see section 42 CFR 417.407). By contract, an HMO/CMP is not free to transfer the risk of loss for medical liability expenses without entering a novation agreement with HCFA. Thus, at all times, a contracting HMO/CMP is directly liable and responsible for the delivery of health services to Medicare enrollees. HCFA recognizes that where a substantial portion of the Medicare enrollees are treated through risk-bearing contracts, that such contractors' performance significantly affects the availability, accessibility, and quality of care provided to Medicare beneficiaries. We find, however, that the term "risk-bearing subcontractor" is too broad, needs to be defined, and needs to be considered in the overall context of the contracting organization. HMO/CMPs frequently subcontract on a risk basis with physicians, home health agencies, and other small health care providers, suppliers, and practitioners. To require each of these small subcontractors to meet financial solvency standards would impose a significant burden to network model HMO/CMPs which would not be effective.

GAO Recommendations

That the Secretary direct the Administrator of HCFA to (1) reduce the adjusted average per capita cost (AAPCC) administrative cost loading factor by recalculating it using paying agents' marginal costs and a factor to account for paying agents' continued involvement in processing HMO enrollee claims; and (2) collect from the HMOs, payments due under the Option B agreements because the intermediaries processed the claims.

Additionally, because the methodology used by HCFA to pay risk-based HMOs currently overpays them on average, the Secretary should direct the Administrator of HCFA to reduce the rates to more accurately account for the health status of HMO enrollees. Our analysis indicates that a 5-percent rate reduction would currently be appropriate given the variation in health status between HMO enrollees and the general Medicare population.

Department Comment

Although GAO has not stated it directly, the report implies that GAO has determined that the AAPCC is not "actuarially equivalent" as required by Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). We disagree with this assessment. GAO's conclusion is based primarily on a mortality study comparing HMO mortality with expected mortality. We believe that the study contains errors and conceptual problems which render its conclusions invalid.

Basically, GAO compares HMO mortality rates with national average mortality rates, where both the national average and HMO mortality rates are adjusted for age and sex. Although GAO attempts to make adjustments for institutional and welfare status, these adjustments are subject to a degree of error which cannot be measured. However, the AAPCC adjusts for not only age, sex, welfare status, and institutional status; but geographic area, and presence of end-stage renal disease (ESRD). Thus, GAO would need to develop mortality rates that are adjusted for all of the various classes in the AAPCC in order to produce a valid study of mortality differentials. Readily available mortality data indicates that in Florida (where over 50 percent of the HMO population studied by GAO resides) the mortality rates for the over-65 population are only 84 percent of the national average used by GAO. In addition, HMO's do not enroll (and are not required to enroll) ESRD beneficiaries who have extremely high mortality rates compared to other Medicare beneficiaries of the same age and sex. The AAPCC is appropriately adjusted for geographic area and ESRD status, but GAO did not make adjustments for these factors.

In summary, because of the nature of the adjustments that were made, the absence of all appropriate adjustments, and the lack of a demonstration that there was a significant statistical difference between actual and expected mortality results, we do not believe that valid conclusions can be drawn from the GAO study. Even if the GAO mortality comparison was valid, the GAO method for defining the relationship between health care costs and mortality rates is subject to a large degree of error. GAO used the results of a 1978 study showing that, for Medicare beneficiaries aged 67 and older, those who die have Medicare expenses which are 6.2 times those who live. GAO, in its study, implicitly assumed that this ratio is uniform across all beneficiary categories and by cause of death. We do not agree with GAO's assumption. For example, a person who dies of cancer may incur more than six times the Medicare expenditures of the average person who survives; but a person who dies in an accident will incur much less. Likewise, this ratio for aged beneficiaries is probably different from that for ESRD beneficiaries. Thus, we believe the GAO assumption that the 6.2 loading factor can be applied uniformly across different causes of death and different classes of beneficiaries is incorrect.

GAO would have to develop ratios by cause of death and by the same beneficiary categories used in the AAPCC in order to produce a valid relationship between mortality and health care expenditures. We believe such an adjustment to the AAPCC would be cumbersome and impractical to implement. In addition, the study used by the GAO applies only to Medicare beneficiaries aged 67 and older. Thus, the study does not apply to the more than 20 percent of Medicare beneficiaries who are under age 67.

Additionally, GAO concludes that the administrative cost loading factor is overstated by at least 25 percent. This conclusion is based upon GAO's presumption that the administrative cost loading factor was intended to pass on to HMOs the administrative costs which would be saved because carriers and intermediaries would no longer be involved in processing HMO enrollee claims; however, neither the legislative language of Section 114 of TEFRA nor the committee language supports this presumption. In fact, many precedents have been set which suggest that this presumption is incorrect. Medicare does not reimburse carriers and intermediaries for the marginal costs of processing claims, nor does it reimburse hospitals for the marginal costs of treating Medicare beneficiaries. In all cases where Medicare reimburses on a cost basis, it reimburses on the basis of allocated costs. Moreover, based on the wording of the law, it might well be presumed that the administrative loading factor was intended to compensate HMO's for the cost of doing their own administration, rather than passing on to them the marginal savings achieved in claims processing costs of carriers and intermediaries. Thus, we do not agree with GAO's recommendation that the administrative loading factor be reduced.

In addition, we do not agree with the GAO recommendation that reimbursement to Medicare risk organizations is excessive and ought to be reduced by 5 percent. GAO maintains that HMOs do not enroll members whose health status is representative of the overall Medicare population, but rather enroll a healthier population. This recommendation is based upon the finding that HMOs experienced only 74 percent of the projected mortality of their enrollees.

While the issue of biased selection is a potential problem, we do not believe the GAO recommendation is supportable because it has drawn upon a single indicator, i.e., mortality rates, to examine health status. It is possible that mortality rates are lower because of the provision of comprehensive and preventive services in the prepaid setting. Further, there is evidence that some risk contractors are experiencing adverse risk selection because of the more comprehensive benefits they are providing. We support continued investigation of ways to adjust HMO reimbursement for enrollee health status, and to determine the extent to which adverse or favorable selection may occur. HCFA currently has two studies underway to examine these critical issues. One study focuses on adjustment of reimbursement based on prior (preenrollment) utilization of beneficiaries. In addition, our evaluation of the experience of the demonstration projects will examine the selection phenomenon and provide information about the appropriateness of adjusting the rating methodology.

HCFA is currently taking action on GAO's recommendation that HCFA should collect from the HMOs payments due under the Option B agreements because the intermediaries processed the claims. More specifically, each month, based on an estimate of intermediaries' payment of HMO/CMP claims, we deduct money from the HMO/CMP payments. Currently, for pre TEFRA payments, HCFA is comparing monies withheld against intermediary payments to arrive at a final reconciled balance.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to test the Florida HMOs' internal controls over claims transferred to them by the intermediaries and carriers. This could be accomplished by HCFA taking a sample of denied part B claims and paid part A bills recently transferred from its paying agents and verifying

that they have been accounted for and appropriately acted upon by the HMOs. Alternatively, the problem could be corrected by requiring the paying agents to obtain receipts for the documents transferred.

Department Comment

We agree with this recommendation and HCFA is working with its regional office to develop a standardized protocol which will be used to monitor HMOs' activities and processes with respect to claims transferred by the intermediaries and carriers.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to:

1. Develop a standardized explanation of the Medicare appeals process and provide it to the HMOs for inclusion in their handbooks or other documents provided to all Medicare enrollees.

2. Provide to the HMOs guidelines establishing standards they must use in providing information on their internal grievance procedures to all enrollees.

Department Comment

Although we agree in concept with this recommendation, it should be addressed in the context of those numerous steps HCFA has already taken to ensure that Medicare beneficiaries are aware of their appeal rights. For example:

- all HMOs/CMPs must have an ongoing grievance and appeals system in order to qualify for a TEFRA contract (this contractual requirement is carefully reviewed by HCFA personnel prior to awarding the HMO/CMP a Medicare contract);

- the Manual currently used by those HCFA staff monitoring these contracts spells out in great detail the plan's contractual requirements in this area and how HCFA staff will monitor the process to ensure it is in place and effectively operating;

- the Manual used by the HMOs/CMPs (Publication 75) to administer the Medicare contract also spells out in great detail their responsibilities relative to the operation of Medicare appeal rights;

- all of the plans' marketing materials (which the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) has now mandated be subject to HCFA review and approval prior to approval of a contract) must clearly spell out to the beneficiaries the Medicare appeal rights; and

- each month, HCFA's Central Office sends to each new enrollee in a risk contract a letter reminding the beneficiary of the lock-in provision as well as reminding him/her of the Medicare appeal rights.

However, since we agree with GAO that this is an important area and one that is potentially subject to misunderstanding by the plans, we will develop a standardized explanation of the appeals process for dissemination to the plans.

With respect to the second part of the recommendation, misunderstandings on behalf of the plans may arise because HMOs have an internal grievance procedure for all of their enrollees. This same procedure as well as Medicare's appeal procedures apply to their Medicare beneficiaries. It is critical that the organizations are able to distinguish between the two and not only provide the information to the enrollees but provide the information to their claims adjudicators. We will develop the necessary guidelines.

GAO Recommendation

That the Secretary require the HCFA Administrator to provide policy guidance to the TEFRA HMOs on marketing activities similar to the guidance furnished the demonstration HMOs in February 1984.

Department Comment

An HMO's compliance with all of its contractual obligations, including those pertaining to marketing (42 CFR 417.428 ff) is routinely monitored by HCFA and, as GAO points out, COBRA requires TEFRA HMOs to submit marketing materials (used on or after April 1, 1986) to HCFA at least 45 days before issuance. This further strengthens the agency's oversight capabilities.

Advance Comments From the National Medical Management

NATIONAL
MED CAL MANAGEMENT

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MIAMI, FLORIDA 33156
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May 28, 1986

Mr. Richard L. Fogel
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

AV-MED, Inc. appreciates the opportunity to comment on your Draft Report· "Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations." We hope these comments will be useful to you and others in the further consideration of your report. We also hope your final report will be beneficial to Medicare beneficiaries nationwide.

Our comments are presented in the same order as the Draft text and no priority should be assumed.

Page 40. Reference is made to AV-MED's filing with Florida HRS of a corrective action plan to have external peer review conducted by non-HMO staff.

An external peer review was conducted by the University of Miami Medical School, non-HMO medical staff, in February of 1985. Another such review has been conducted in May 1986.

Chapter 4· Medicare HMO Payment Rates are Excessive

The entirety of Chapter 4 addresses GAO's contention that Medicare HMO payment rates are excessive. It is important to note that in the competitive environment of South Florida a much more comprehensive benefit package is offered to the Medicare beneficiaries. The fact that the largest single Medicare HMO in the nation, IMC, is providing a product with very comprehensive benefits, no deductibles or co-payments, and no premium, requires other competing HMOs to offer a similar product.

Advance Comments From the National Medical Management

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Chapter 4 Medicare HMO Payment Rates are Excessive

The entirety of Chapter 4 addresses GAO's contention that Medicare HMO payment rates are excessive. It is important to note that in the competitive environment of South Florida a much more comprehensive benefit package is offered to the Medicare beneficiaries. The fact that the largest single Medicare HMO in the nation, IMC, is providing a product with very comprehensive benefits, no deductibles or co-payments, and no premium, requires other competing HMOs to offer a similar product.

NATIONAL
MEDICAL MANAGEMENT

Mr. R. L. Fogel
Page two
May 28, 1986

The GAO Report argues that mortality rate is an appropriate indirect measure of health status and thus, because the analysis of 27 HMOs lacked a representative mix of enrollees, as measured by mortality rates, the reimbursement is too high. The question comes to mind as to whether or not the South Florida enrollees were similar to the norm and secondly, whether mortality rates are a valid indirect measure of health status and associated health cost.

While "windfalls" to HMOs may or may not be occurring, it is also important to note that South Florida leads the nation in the number of HMO Medicare enrollees. The transition from fee-for-service to HMO for enrollees has been the objective of both the Domonstration project and TEFRA. South Florida's HMOs have been successful in this effort partly because of the savings to the Medicare beneficiary as well as the savings to the taxpayers. If HCFA desires to save more dollars and reduces payment to HMOs, it is likely that premiums will be charged and enrollment will decrease.

Further, there is no consideration of RISK - the HMOs are at risk and the risk is considerable. Risk is an associated cost of conducting business.

Finally, we point to the fact that AV-MED was the first HMO to offer services to Medicare beneficiaries in the Tampa Bay area. AV-MED is a mature HMO and has consistently managed its programs in a profitable manner. The losses AV-MED suffered in the Tampa Bay Medicare program were such that HCFA was notified of our intent and subsequently we terminated our TEFRA contract for the area. If reimbursement had been at the 89 percent or lower level of AAPCC as proposed by GAO, the losses would have threatened the financial stability of the corporation. Should an 89 percent of AAPCC be imposed, it is likely AV-MED would also terminate its Miami-based program as current margins are at breakeven.

NATIONAL
MEDICAL MANAGEMENT

Mr. R. L. Fogel
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May 28, 1986

Page 89 - Disenrollments

AV-MED believes the high disenrollment rate of Medicare beneficiaries is due primarily to two factors: 1) the highly competitive market and 2) the fact that most of the enrollees are joining an HMO for the first time and find the HMOs are not as they perceived them to be in terms of freedom of choice of physicians. It is noted that 79.8 percent of AV-MED's disenrollments occurred in the first two months of membership.

It is also noted that during the period of the disenrollment study, calendar year 1984, AV-MED was the first HMO to offer coverage to Medicare beneficiaries in the Tampa Bay area. The response far exceeded AV-MED's expectations and thousands of Medicare beneficiaries enrolled in the program during the first few months. Many of these individuals did not like the "lock in" provision of HMOs and this, coupled with increased competition, and AV-MED's commitment to rapidly disenroll members desiring to be disenrolled, account for the high percentage of disenrollment in the first two months of 1984 in AV-MED's Medicare program.

We hope these comments are useful to you.

Sincerely,

Robert T. Jones
Senior Vice President

RTJ/od

Advance Comments From Comprehensive American Care, Inc.

Benjamin Leon Jr
President and Chief Executive Officer

May 28, 1986

Richard L. Fogel
Director
Human Resources Division
United States General
Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Re: Comments on Draft GAO Report

Dear Mr. Fogel:

On behalf of Comprehensive American Care, Inc. ("CAC"), I would like to express our appreciation for the opportunity to review and comment on a draft version of the proposed General Accounting Office ("GAO") report entitled "Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations."

Generally speaking, we believe that the draft GAO report presents a fair and accurate factual discussion of matters pertaining to CAC and the other Florida Medicare HMO demonstration projects, at least to the extent CAC is aware of the relevant circumstances. CAC also believes that the GAO draft evidences an earnest and largely successful effort to present a balanced analysis of the issues addressed in the report.

Several of GAO's tentative conclusions and recommendations could obviously have significant consequences for Medicare beneficiaries and HMOs in South Florida, as well as for the HMO industry and beneficiaries nationwide. We believe that the report will serve as a useful vehicle for initiating responsible discussion among the public, the HMO industry, and the governmental entities responsible for promoting effective and efficient health care benefit programs for the nation's Medicare population. CAC will therefore limit its substantive comments,

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at this time, to two aspects of the draft report; namely, the conclusions reached regarding the reasonableness of Medicare's HMO payment rates and the necessity for enforcement of statutory standards regarding patient enrollment mix.

Based on a one-year mortality study which compared actual and actuarially predicted mortality rates for patients enrolled in 27 pre-TEFRA risk-based HMOs, GAO concluded that the applicable Medicare adjusted average per capita costs ("AAPCC") were excessive and should be reduced by 5 percent. GAO based this recommendation primarily upon its conclusion that Medicare enrollees in the subject HMOs were healthier than the general Medicare population, as reflected in an apparent lower-than-projected mortality rate for the HMO enrollees. GAO therefore recommends that HCFA utilize a "health status" factor in computing future AAPCC rates and that, based on GAO's single year mortality rate study, a 5 percent rate reduction to the AAPCC be implemented to reflect more accurately the actual health status of HMO enrollees.

CAC respectfully submits that GAO erred in its conclusion that the AAPCC is excessive and requires use of a "health status" factor to reflect accurately the costs of treating Medicare beneficiaries enrolled in an HMO. GAO's analysis of this issue was based upon mortality data for only a single year. Such a limited data base is clearly inadequate to measure accurately the level of costs/risk associated with treating a defined population over an extended period of time. An HMO's cost of treating patients follows a fluctuating cost curve that must be viewed in a long-term perspective.

In addition, unlike GAO's limited mortality rate study, the Secretary of Health and Human Services undertook a comprehensive and sophisticated analysis of all relevant actuarial factors before certifying to Congress, pursuant to statutory mandate, that the Health Care Financing Administration ("HCFA") was reasonably certain that the methodology used for calculating the AAPCC would assure actuarial equivalence in comparing the health care needs of Medicare beneficiaries enrolled in HMOs with those of beneficiaries who receive care in the fee-for-service sector. Thus, CAC submits that the Secretary's computation of the AAPCC comes much closer to identifying the actual costs of treating Medicare patients than does GAO's arbitrary conclusion that the AAPCC rates are 5% too high because they do not include an enrollee "health factor" adjustment.

Richard L. Fogel
May 28, 1986
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The Secretary has, in fact, already rejected the suggestion that a health status factor is necessary in order to calculate accurately the AAPCC. In the preamble to the final TEFRA regulations, HCFA reported that it had considered including such a factor in the AAPCC methodology, but that "[a]n independent actuarial consultant has advised us that a health status adjustment would not result in improvement in the AAPCC methodology. . . ." 50 Fed. Reg. 1314, 1330 (1985). CAC believes that the extremely limited GAO study does not demonstrate the need for the introduction of such an inexact factor into the AAPCC methodology at this time.

Finally, CAC was surprised to learn through the GAO draft report that HCFA has no enforcement mechanism in place to ensure that all HMOs comply in a timely fashion with the statutory requirement that an HMO meet the 50-50 composition of enrollment standard limiting the percentage of Medicare and Medicaid enrollees in a qualified organization. Mindful of past experiences involving abuses in both the Medicare and Medicaid programs, Congress has determined that good legislative policy requires safeguards against an organization being too heavily weighted with program enrollees so that its operation becomes little more than a "Medicare or Medicaid mill." Thus, CAC believes that, as a matter of good policy and basic fairness, HCFA should establish mandatory interim goals to ensure timely compliance with enrollment mix standards by all HMOs. Without these graduated enrollment limitations and an earnest enforcement commitment to ensure compliance, it is highly unlikely that the enrollee balance contemplated by Congress will be achieved within a reasonable time period. There is no good reason for a significant delay. The interests of the Medicare program will be better served by fair competition and balanced enrollment mixes among HMOs than by indefinite extensions and special accommodations to any particular organization.

Thank you once again for affording CAC the opportunity to comment on the draft GAO report. We look forward to receiving a copy of the final report once it is issued.

Sincerely yours,

Ben Leon Jr.

Benjamin Leon, Jr.
President and Chief Executive
Officer

BY HAND

Advance Comments From Healthamerica HMO Corporation (Florida)

3310 West End Avenue
Nashville, Tennessee 37203
(615) 385-7300

HealthAmerica

June 4, 1986

Richard L. Fogel, Director
UNITED STATES GENERAL ACCOUNTING OFFICE
Human Resources Division
Washington, D.C. 20548

Dear Mr. Fogel:

We appreciate the opportunity to comment on the draft GAO report which discusses the four Medicare Demonstration HMO's in South Florida.

In general, we are satisfied with the report as it relates to HealthAmerica, and we are happy to note that GAO at the present time finds no fault with the way the HealthAmerica Plan in Fort Lauderdale is operated.

We noted several places in the report where reference was made to problems encountered by HealthAmerica enrollees during 1983 and 1984. We were pleased to note that all those references indicated that as of early 1985, all the outstanding issues had been favorably resolved. For the record, HealthAmerica purchased the Broward plan in 1985.

We wish to comment on the conclusions made concerning the level of payment to HMO's based on 1984 mortality statistics. In our opinion, these conclusions are based on insufficient data to support the statement that HMO's are reimbursed at too high a level for the services rendered. A review of HealthAmerica's ACR submittals over the last several years would indicate that contrary to the GAO's assertion that the HMO's are overpaid, we appear to be underpaid.

We at HealthAmerica have a continuing commitment to provide quality services to all segments of the population residing in the Fort Lauderdale area, and hope to continue working with HCFA in the Medicare Risk Program in the future.

Richard L. Fogel
May 22, 1986
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Once again, thank you for the opportunity to comment on the draft report. We are pleased that the General Accounting Office finds that HealthAmerica is currently in compliance with the items covered by this report.

Very truly yours,

Philip N. Bredesen
President
HEALTHAMERICA HMO CORPORATION (FLORIDA)

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