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medical care, depending on a state's per capita income. In 1985, the federal cost of Medicaid was \$38 billion. The Department of Health and Human Services (HHS) administers Medicaid at the federal level. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

Concerned over the rapid growth in Medicaid costs and seeking to provide more cost-effective care, the Congress through the Omnibus Budget Reconciliation Act of 1981 gave states the option to develop alternative delivery systems for Medicaid recipients. HealthPASS is one such system.

HealthPASS began serving Medicaid recipients in south and west Philadelphia in March 1986. Pennsylvania's DPW designed the program to save approximately 10 percent of the fee-for-service costs of serving this population. DPW contracted with a private entity, Penn Health Corporation, a wholly owned subsidiary of Maxicare, Inc.,<sup>1</sup> to administer HealthPASS as a health insuring organization (HIO). As an HIO, HealthPASS assumes financial responsibility for the health care of Medicaid recipients in its service area in exchange for a fixed, prepaid, monthly payment or capitation rate for each enrollee. Penn Health does not provide care directly, but contracts with providers (e.g., hospitals and physicians) for medical services. If the costs of providing Medicaid benefits exceed the fixed monthly payment, the HIO suffers a loss up to the limit specified in the contract.

To establish an HIO, Pennsylvania had to obtain a waiver of Medicaid regulations from HCFA. The waiver allowed HealthPASS to (1) restrict access of recipients in its service area to preselected providers, (2) establish the program in one specific geographic area rather than statewide, (3) pay higher than equivalent fee-for-service fees for certain kinds of services, and (4) arrange for the use of the case manager approach for delivering health care.

Under the case manager approach, each Medicaid recipient is required to select or is assigned to a physician or group who becomes responsible for the recipient's primary care and serves as a gatekeeper for access to other types of health services. Except for emergency care and a few other services such as family planning and outpatient drug and alcohol abuse treatment, recipients must go through their case managers to

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<sup>1</sup>At the inception of the program Penn Health was owned by HealthAmerica, Inc. which was acquired by Maxicare in November 1986.

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obtain access to services. In addition to rendering primary care, the case manager coordinates the patient treatment plan and authorizes referrals to specialists and hospital admissions. This coordination of services through case management is the mechanism that in theory can lead to reductions in program costs while maintaining quality of care.

To encourage case managers to manage care effectively, Penn Health pays them on a capitated basis; the fixed monthly payment for each enrollee is designed to cover care provided by both the case manager and any referral providers. As in the case of the HIO itself, case managers can earn additional income if they keep the actual cost of their services and the services of referral providers below the capitated fee level. In addition, although case managers are not at direct financial risk for inpatient hospitalizations (and certain other services such as hospital emergency room treatments), they share in any aggregate savings on such services achieved by HealthPASS.

As with all plans that involve a capitation approach to Medicaid reimbursement, a major concern is that access and quality of care remain at least equal to that under the traditional fee-for-service system. With HealthPASS, as under the regular Medicaid program, the state is responsible for monitoring the program and assuring HCFA that access and quality are maintained. Additionally, the waiver agreement between HCFA and DPW spells out specific requirements, including an external peer review and independent program evaluation, for assessing access and quality.

The HealthPASS waiver is effective for 2 years, through February 2, 1988. In November 1987, DPW requested that HCFA approve a 2-year renewal. HCFA has 90 days to review and approve or disapprove the request. The Secretary of HHS must concur with a disapproval decision. No new waivers of this type can be approved because a series of legislative changes since 1985 limit the Secretary's discretion in granting similar waivers.

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## Objectives, Scope, and Methodology

As you requested, the objectives of our review were to monitor the implementation of the HealthPASS program and brief the Subcommittee on the progress it has made and problems being encountered. We provided the Subcommittee staff with quarterly briefings.

Our monitoring was done at HCFA headquarters in Baltimore, HCFA's regional office in Philadelphia, the Pennsylvania DPW in Harrisburg, and

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an unaudited pretax loss of about \$7.8 million, which it and the state attributed to an initial capitation rate that was too low and substantial underestimation of the hospital utilization rate among the recipients Penn Health was to serve.

Not only is setting Medicaid capitation rates complex and often controversial, according to a recent HCFA evaluation of seven capitated Medicaid demonstration projects, but it may be the single most important factor in determining program viability. In the programs HCFA reviewed, questions often emerged about (1) the methodology used to calculate payment rates (e.g., the categories of Medicaid recipients for whom to compute rates) and (2) the assumptions used to adjust rates for such factors as inflation and changes in program requirements. Such issues need close scrutiny, given the importance of capitation rates to program cost-effectiveness and viability.

Under Medicaid regulations, capitation rates cannot exceed what the state would otherwise pay for the medical care of a comparable group of recipients if the care were provided in the fee-for-service sector. Calculating accurate capitation rates is complex because:

1. Often the data used are several years old and must be updated to reflect expected costs per eligible recipient in the year for which the rates apply.
2. Obtaining accurate counts of eligible Medicaid recipients is difficult.
3. Working from a common database, the costs and recipients whose services are paid solely with state funds must be separated from those eligible for federal financial participation under Medicaid.

## HealthPASS Rates

In calculating the HealthPASS payment rates, Pennsylvania aimed to save 10 percent over what it otherwise would have paid in the fee-for-service sector. It calculated the rate for the first year of the HealthPASS contract (effective through February 1987) from its 1984 claims data for Philadelphia County, updated to reflect program changes and inflation since 1984. After negotiations with the contractor and reviews by HCFA, all parties agreed that an average capitation rate of \$90.85 per member per month would enable the state to achieve a 10-percent savings and the contractor to operate profitably. The contract also contained a risk-sharing arrangement that would compensate either the contractor or the

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Medicaid program should hospital utilization be above or below preset levels.

Underlying the payment rate was the assumption, according to Penn Health's actuarial consultant, that HealthPASS would be able to achieve a hospital utilization rate of 811 days per 1,000 enrollees. In reviewing the payment rates, neither the state, the contractor, nor HCFA questioned the achievability of this utilization rate, and the comparable fee-for-service statistic was unavailable. Penn Health's first-year hospital utilization experience, 1,251 days per 1,000 enrollees, was substantially above the assumed rate. In August 1987, the state analyzed its claims data and reported to HCFA that the annualized Medicaid hospital utilization rate being experienced in Philadelphia County (outside of HealthPASS's service area) was 2,145 days per 1,000 enrollees compared with HealthPASS's rate of 1,251 per 1,000 enrollees for a similar period.<sup>2</sup>

Other factors underlay the computation of the capitation rate:

1. It was assumed that the contractor would be able to achieve lower costs than the fee-for-service Medicaid costs.
2. The rate included Penn Health's administrative costs, estimated to be about 7 percent of Penn Health's revenues under the contract.
3. Unless it could realize a profit of 5 percent on the project's revenues, Maxicare stated, it would be unwilling to continue its contract with the state.

To absorb the contractor's administrative costs and meet the state's savings and the contractor's profit goals would require about a 20-percent reduction from expected fee-for-service costs. Neither the state in its preparation of the waiver submission nor HCFA in its review addressed the achievability of such a reduction.

#### Contract Renegotiated

In November 1986, when its known losses on HealthPASS reached \$2 million, Maxicare submitted its notice to terminate the contract with Pennsylvania at the end of the first year. This prompted the state to negotiate an arrangement that ultimately led the contractor to agree to continue for another year. Using data more current than that available

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<sup>2</sup>Utilization rates cited exclude hospitalizations of beneficiaries eligible for both Medicare and Medicaid because Medicare is the primary payer in such cases.

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when it computed the first-year HealthPASS rate, DPW recomputed the rate. It now believes that, instead of being 90 percent of the fee-for-service cost, the capitation rate of \$90.85 per member per month was actually about 80 percent of such costs. Using this more current data, the state (1) agreed to increase the capitation rate for the second year of the HealthPASS contract, from \$90.85 to \$106.44 (17 percent), and (2) renegotiated the contract's risk-sharing arrangements to limit any contractor losses to a total of \$2 million for the first 2 years of operations. If the initial risk-sharing provision of the contract were applied, we estimated, Penn Health's first-year loss would have been approximately \$3.7 million.

The practical effects of the new risk-sharing agreement were to

- forgive a substantial portion of the contractor's first-year losses;
- allow the contractor to operate during its second year without risk; and
- make uncertain at this time, because of the state's decision to underwrite all losses in excess of \$2 million, the ultimate contract costs of the program.

In previous reviews, we recounted the transference of risk from the risk-based contractor to the state Medicaid program. In a 1978 GAO report, we found that firms with Medicaid insurance contracts to administer aspects of state Medicaid programs experienced financial difficulties.<sup>3</sup> The contractors charged that inaccurate, unreliable, and incomplete Medicaid program data caused them to underestimate their costs and underbid the contracts. To avoid further losses and reduce their underwriting risk, these firms terminated their agreements, refused to extend them, or pressured the state to renegotiate the contract in the contractor's favor. In our 1978 report, we recommended that HHS not approve changes that eliminate or reduce a contractor's underwriting risk.

HCFA incorporated these recommendations into regulations that prohibit recoupment of losses and elimination of contractor risk. Specifically, the regulation prohibits recoupment of prior losses through a change in the capitation fee.

In the case of HealthPASS, HCFA approved a change in risk-sharing provisions because it did not consider payments arising from them to be a change in the capitation fee. At the time of approval, the ultimate cost

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<sup>3</sup>Medicaid Insurance Contracts—Problems in Procuring, Administering, and Monitoring (GAO/HRD-77-106, Jan. 23, 1978).

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of the amended risk-sharing provision was not known because the magnitude of Penn Health's losses were not known. As a result of Penn Health's higher-than-expected first-year losses, we estimate, the amended risk-sharing provision in effect reduced Penn Health's losses by at least \$1.7 million (shifting such losses to the state and federal governments). In a letter dated November 19, 1987, we have asked HCFA to determine whether this change violated federal regulations prohibiting recoupment of losses and elimination of contractor risk. (For a more detailed discussion of these issues, see app. I.)

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In summary, because of the many assumptions required for establishing Medicaid capitation rates, there is little prospect of eliminating disputes over their reasonableness, particularly when contractors incur losses. The rate-setting process is important to program viability, from both the contractor's and Medicaid's perspective. Thus, development of benchmark statistics such as (in the case of HealthPASS) fee-for-service hospital utilization rates, would help in sorting out, when disputes arise, whether the problem is with the rates, the savings goals, or the contractor's performance. The causes of Penn Health's losses still cannot be determined, although DPW and HCFA agree that the reimbursement rates most likely were understated. Complicating factors include (1) lack of audited financial statements from Penn Health (the first of which are not due until Dec. 1987), (2) Penn Health's apparent continuing losses during the second program year (which could exceed first-year losses, based on Penn Health's unaudited statements for the first 6 months under the new rate), and (3) difficulties and limitations Penn Health has experienced in implementing its case management approach (as discussed in the next section). As case management is a key mechanism for controlling utilization, some of the losses probably can be attributed to the latter problems.

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### Case Management a Key Element

Case management in HealthPASS is an important element for achieving program utilization and quality of care goals. The case management approach departs substantially from delivery of services in Philadelphia under the traditional fee-for-service Medicaid program. Most recipient services are intended to be coordinated through the case manager, who acts as gatekeeper to restrict unnecessary services and maintain continuity of care. Several factors reduced the effectiveness of this approach under HealthPASS.

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percent of recipients were assigned individual physician case managers, with the remainder assigned to sites.

Implementation of an effective case management system is the key to achieving the program's dual objectives—substantial cost savings and maintenance of quality and access to care. That it will take a number of years for the Medicaid recipients and providers to become educated in the use and provision of care under the case management approach is generally agreed. Given this and the limitations in case management as operating in HealthPASS, HCFA and state officials will continue to monitor the program closely, they told us. They expect to help assure progress in correcting known problems and ultimately to determine the workability of the case management approach.

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### Quality Assurance: Mechanisms Required

Capitation reimbursement, such as that used by HealthPASS, creates strong incentives for providers to reduce utilization to cut costs. This gives rise to concerns over quality of care. Considerable attention was given to quality control in developing the HealthPASS program, and HCFA's waiver approving HealthPASS was explicit in requiring quality assurance mechanisms. These mechanisms included (1) a complaint and grievance system to give recipients a process for resolving problems; (2) a quality assurance program requiring Penn Health and DPW, respectively, to conduct internal and external peer reviews of cases to monitor quality of care; and (3) development of utilization data for HealthPASS overall and by case manager, for DPW's use in monitoring utilization of services against standards developed specifically for that purpose.

The complaint and grievance system was implemented on time and has been functioning since HealthPASS began. Recipient complaints are handled principally through a telephone "hotline" staffed around the clock to address both inquiries and complaints. During the program's first year, the hotline received over 86,000 calls from recipients, according to HCFA. Of these, about 780 were classified as informal complaints (mostly relating to problems centering on the doctor/patient relationship) with the remainder apparently classified as inquiries. If a complaint is not resolved to the recipient's satisfaction, it is classified as a grievance, for which there are several stages of resolution or appeal. No recipient's complaint was classified as a grievance the first year of HealthPASS operations, according to Penn Health officials.

The quality assurance program was only partially implemented in HealthPASS's first year of operations. Penn Health was required to conduct



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internal peer reviews of a random sample of outpatient cases at the case manager sites and inpatient cases at participating hospitals, using sampling methods and review criteria set forth in the waiver. Penn Health began the case manager reviews 7 months into the program year and the hospital reviews 8 months later than called for in the waiver. Also, Penn Health did not adhere to the required sampling methodology in conducting either of the review activities—it used smaller samples than required, and the case manager reviews were not random.

More importantly, however, the reviews did not focus on quality of care, according to a HCFA assessment of the process. Instead of covering the criteria specified in the waiver, the hospital review activity focused on whether the admission was necessary and/or the length of stay exceeded requirements, according to HCFA. Case manager reviews, HCFA found, centered on physician charting practices with no evidence, in the majority of cases, of a Penn Health reviewer's evaluation of the quality of care provided.

In addition to Penn Health's internal review function, DPW was required under the HealthPASS waiver to contract with an independent firm to perform external peer review of the quality of care provided by case managers. This external review, according to HCFA, was structured to be the "... keystone of the Commonwealth's quality assurance process." Because of delays in contracting with the external peer review organization, the program was not implemented until July 1987, and actual case reviews did not begin until October 1987. Consequently, data were not available at the time we completed our fieldwork on the results of the external peer review.

The third mechanism required under the waiver for quality assurance was monitoring of HealthPASS recipients' utilization of health services. DWP was required to do this by using standards it developed specifically to detect potential patterns of underuse or other quality problems. While DPW made some comparisons between HealthPASS utilization rates and the standards, the results were not useful because the standards, according to DPW officials, were based on estimates they now believe may have been incorrect. At the time we completed our fieldwork, DPW reported to HCFA that it was in the process of collecting data on which to base revised standards. HCFA did not offer the state any specific guidance on what data the standards should be based on, and DPW has offered HCFA no information on the data it will use.

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service costs in Philadelphia County for 1985-86, DPW calculated that the first-year capitation fee should have been \$102.22 per recipient per month rather than the contract rate of \$90.85. The new rate of \$106.44 represented a 4-percent increase over \$102.22. In a January 22, 1987, letter to Elmer Smith, Director of HCFA's Office of Eligibility Policy, DPW claimed that if the first year's capitation rate had been \$102.22 rather than \$90.85 (based on the actual rather than projected fee-for-service rate) the program would have produced a pretax profit of approximately 6 percent. HCFA reviewed DPW's calculation and approved the second-year rate and loss limit provision.

Federal regulations governing HIOS (42 C.F.R. 434.14(a)(4) and (5), respectively) require that contracts with HIOS "specify that the capitation fee will not include any amount for recoupment of any losses suffered by the contractor for risks assumed under the same contract or a prior contract with the agency" and "specify that the contractor assumes at least part of the underwriting risk." The initial contract did contain a clause mirroring the language of section 434.14(a)(4). However, the contract amendment deleted that clause (F.10). Moreover, the increased capitation fee may have included a recoupment for losses suffered by Penn Health for risks assumed under the same contract during the first year of operation. The contract amendment contained a 17-percent increase in the capitation rate for the second year of operation; an increase that DPW contends would have been only 4 percent had it not initially underestimated the fee-for-service equivalent. Further, the new risk-sharing clause, limiting Penn Health's combined 2-year losses to \$2 million (well below the first-year losses sustained prior to the contract amendment), may allow recoupment for first-year losses and, in essence, permit Penn Health to assume no financial risk during year 2 of operation.

On November 19, 1987, we requested HCFA's legal opinion and explanation as to whether the HealthPASS program's contract and amendments conform with federal regulations governing HIOS. We asked for HCFA's interpretation of the term "capitation fee" as it is used in these regulations and also questioned whether the new risk-sharing clause improperly allows recoupment of first-year losses. A reply was requested within 20 days from the date of the letter.



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