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Quality of Care Provided Medicaid Recipients by Chicago-area HMOs

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the Environment
Committee on Energy and Commerce
House of Representatives

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here to discuss our recent report on oversight of Chicago-area health maintenance organizations (HMOs) serving Medicaid recipients.[1] Our review was requested by Representative Cardiss Collins after the Chicago Sun-Times alleged, in a series of articles in October 1987, that these HMOs were providing poor quality care. The two largest Chicago-area HMOs--Chicago HMO and Med Care--were, among other things, alleged to be seriously delaying care for children and failing to provide high-risk infants with proper follow-up care.

Medicaid pays the Chicago-area HMOs a fixed monthly amount per enrolled recipient (capitation) to cover all Medicaid health services for a recipient. Capitation, therefore, gives these HMOs a financial incentive to control the use of services and assure that only necessary care is provided. Although capitation has significant potential for containing health care costs, it also poses the danger of diminished quality of care. This could happen should an HMO try to cut costs by inappropriately reducing services to Medicaid recipients.

Since 1974, the Illinois Department of Public Aid (IDPA) has contracted with HMOs for the provision of health services to

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[1]Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

Medicaid recipients. Initially, few Medicaid recipients enrolled in HMOs. In 1984, the state expanded the program to include contracting with nonfederally qualified HMOs. Subsequently, Medicaid enrollments grew rapidly. As of January 1989, about 88,000 Medicaid recipients were enrolled in the seven HMOs participating in the program.

Our review focused on the adequacy of federal and state oversight of the Chicago-area HMO program. My testimony today will address three areas of concern:

-- inadequate identification of, and follow-up on, quality-of-care problems;

-- inadequate documentation of the services provided so as to permit an evaluation of the quality of care; and

-- financial incentives given to HMO physicians that could cause them to underserve Medicaid recipients.

INADEQUATE IDENTIFICATION AND FOLLOW-UP ON QUALITY-OF-CARE PROBLEMS

To begin, we are concerned about whether needed health care services are being provided to Medicaid recipients enrolled in

Chicago-area HMOs. One possible indication that Medicaid recipients are having trouble getting needed services is the high turnover of Medicaid recipients. Over 58,000 Medicaid recipients voluntarily left their HMOs during fiscal years 1986 through 1988 to return to fee-for-service.[2]

Although such disenrollments could indicate widespread dissatisfaction with the services being provided, the state has not conducted, or had the individual HMOs conduct, patient satisfaction surveys. Such a survey was planned but, state officials told us, was not done. They said the envelopes were stuffed and ready to be mailed when they were told to discontinue the survey. State officials told us they plan to conduct a patient satisfaction survey but did not know when it would be done.

There is also little evidence in the medical records that preventive health services--such as physical examinations and immunizations--which HMOs are required to provide--are being given to children. Similarly, a peer review organization (Crescent Counties Foundation for Medical Care) expressed concern during reviews in 1987 and 1988 about the adequacy of prenatal care provided to pregnant women by Med Care. A follow-up review by state quality assurance staff in 1989 confirmed the peer review findings and expressed particular concern about the care provided

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[2]Medicaid recipients remain with Med Care only about 5 1/2 months, an HMO official said.

to high-risk mothers, such as those with medical problems or a history of substance abuse. In another example of potential quality-of-care problems, both HCFA and state reviewers identified instances where women were sterilized without a record of their having consented to the procedure. Neither the state nor HCFA adequately followed up to determine whether the problem was simply one of poor documentation in the medical records or a more serious quality-of-care problem.

In addition, auditors from Illinois's Department of Public Aid found that 57 percent of enrollees sampled at five Chicago-area HMOs had no record of having received services from their HMO. Another study by the peer review organization found that 30 percent of the enrollees had no record of services during 1987. The state has not, however, followed up to determine whether services provided were not documented or whether enrollees may have been denied needed services.

INADEQUATE DOCUMENTATION OF SERVICES PROVIDED

That brings me to our second concern and one of the major weaknesses in the Chicago-area program--the lack of adequate documentation of the services provided to HMO enrollees. Without such data--and a computer system to analyze it--it is not possible to tell whether needed services are being provided, but are just

not being documented or whether Medicaid recipients are not receiving needed services. Even if the problem is limited to one of poor documentation, there are reasons for concern. Without complete documentation, the promptness and appropriateness of treatment cannot be assessed. The ability of a physician to make appropriate and prompt treatment decisions can be affected if test results and treatments previously given are not documented in the record.

It was only in fiscal year 1987 that Illinois began (1) requiring HMOs to submit detailed data on the health services provided to Medicaid enrollees and (2) assessing penalties for noncompliance. These actions have not been effective in ensuring the submission of complete and accurate data. As of January 1990, the state had accepted only 40 percent of the utilization data tapes submitted by HMOs. State officials told us that they have now received at least one acceptable data tape from each HMO for each quarter of fiscal year 1989, but they did not know how many more tapes should have been submitted. Without complete and accurate utilization data the state cannot detect possible underserving of Medicaid enrollees and underlying quality-of-care problems.

FINANCIAL INCENTIVES TO UNDERSERVE MEDICAID RECIPIENTS

Our third concern--and among the most serious threats to the quality of care provided to Medicaid recipients by Chicago HMO and Med Care--is the methods these HMOs use to "manage" care. These methods include financial incentives that, in our opinion, encourage underservicing and high turnover in HMO participation.

The financial incentives to control utilization vary by type of HMO. For example, some HMOs provide services through salaried primary care physicians who would not directly benefit financially by limiting the services they provide. Other types of HMOs, however, generally provide financial incentives to physicians to control (1) use of primary care services, (2) referrals to specialists, and (3) hospital admissions. The amount of financial risk transferred from the HMO to an individual physician or group of physicians increases as the physician or group of physicians is made responsible for a wider range of services, such as care by specialists and hospital care.

I want to make it clear that we are not suggesting that all HMOs in general provide poor quality care, as the Department of Health and Human Services asserted in commenting on a draft of our report. Nor are we suggesting that the same risks to patient care exist under all HMOs. However, the incentive payment methods used

by Chicago HMO and Med Care are, in our opinion, among the riskier models.

Med Care and Chicago HMO delegate to small groups of physicians, which function essentially as mini-HMOs, most of the responsibility for managing the care provided. That is, the groups are paid a fixed amount for a wide range of primary care services and are at risk for a substantial portion of the cost of hospital care and specialist services. Because these groups frequently have few primary care physicians and enrollees over whom to spread the risks, a single catastrophic illness can put a financial strain on the group.

Physicians may be forced to pay the cost of some care out of pocket if the cost exceeds the amounts they are paid to care for the patients. Thus, under these arrangements, substantial risk is transferred to the physicians, particularly those who have contracted to care for relatively small numbers of patients. Over half of Chicago HMO's and Med Care's risk-based subcontractors--essentially mini-HMOs--had fewer than 1,000 total enrollees from those HMOs; 6 spread the risks over fewer than 100 enrollees. These physicians may have to make decisions that could cost themselves money or result in inappropriate reductions in service.

We are particularly concerned about the amount of risk transferred to these small groups of physicians because they have

not been required to (1) prove that they are financially solvent, (2) have a plan to deal with insolvency, or (3) enroll private pay as well as Medicaid recipients. Such requirements are intended to help ensure the quality of care provided to Medicaid recipients and must be applied to HMOs contracting on a risk basis to provide services to Medicaid recipients. Neither HHS nor Illinois, however, has mandated that HMOs apply these same requirements to the subcontracting mini-HMOs. This essentially permits the HMOs to circumvent federal regulations by setting up a network of mini-HMOs.

As an example, Med Care's and Chicago HMO's overall enrollments were less than the 75 percent Medicare beneficiaries and Medicaid recipients required by law. However, of the 78 subcontractors with Medicaid enrollees in Chicago HMO, 7 had over 90 percent Medicaid enrollees. Similarly, 9 of Med Care's 25 subcontractors had over 90 percent Medicaid enrollees.

We believe that financial incentive arrangements that expose the physician to substantial financial risk for services provided by other physicians or institutions or closely link financial rewards with individual treatment decisions (1) pose the greatest threat to quality and (2) necessitate the highest level of quality assurance control. These incentives, when coupled with a high turnover rate, raise concerns that physicians may increase profits

by delaying care. The high turnover rate insulates the physician from adverse effects of delaying or denying care.

In conclusion, our report shows that effective quality assurance mechanisms are not in place in the Chicago-area program to counterbalance the strong financial incentives given to Chicago HMO and Med Care primary care physicians to underserve Medicaid recipients. Further, the effects of such incentives on patient care cannot be adequately assessed until the HMOs fully and accurately document the medical care services provided and an effective system is developed to analyze the utilization data gathered.

To address these concerns, our report contains a series of recommendations to the Secretary of Health and Human Services concerning strengthening oversight of Chicago-area HMOs. Both HHS and Illinois generally disagreed with our report, particularly with respect to (1) the appropriateness of the financial incentive arrangements used by Med Care and Chicago HMO and (2) the need to apply appropriate risk-based contracting requirements to subcontracting mini-HMOs. Neither HHS nor the state cited specific actions they planned to take to correct the problems. The lack of specific plans to improve quality assurance efforts heightens our concerns about the quality-of-care provided to Medicaid recipients by Chicago-area HMOs and highlights the need for congressional

action to strengthen controls over the types of financial incentive arrangements used by HMOs.

Accordingly, our report recommends that the Congress amend the Social Security Act to establish (1) a minimum enrollment requirement for HMOs participating in the Medicaid program and (2) risk-based contacting requirements for Medicare and Medicaid that are more consistent. Currently, Medicare has a minimum enrollment requirement for participating HMOs while Medicaid does not. Medicaid requires appropriate contracting requirements to be applied in subcontracts while Medicare does not. We believe both requirements have merit and should apply to both programs.

Mr. Chairman, that concludes my prepared statement. I would be glad to answer any questions that you or other Members of the Subcommittee may have.