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MEDICARE:

HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards

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Committee on Energy and Commerce
Subcommittee on Health and the
Environment
House of Representatives

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SUMMARY

About 1.4 million of the nation's 33 million Medicare beneficiaries are enrolled in health maintenance organizations (HMOs) that have contracted with the Health Care Financing Administration (HCFA) to provide health care in return for a predetermined monthly payment per enrolled beneficiary. HCFA is responsible for assuring that these HMOs comply with Medicare law and regulations.

During the past 5 years, GAO has issued a series of reports that have questioned HCFA's ability and willingness to enforce Medicare requirements when HMOs are unresponsive or untimely in correcting violations. Our most recent report, issued in early November 1991, examined HCFA's oversight of the nation's largest HMO Medicare contractor--the Humana Medical Plan, Inc., in Florida. As in the past, we found that HCFA's attempts to resolve deficiencies at Humana's Florida plan often resulted in little more than documenting the history of the problems.

Humana's Florida plan, which has about 203,000 Medicare enrollees, came into existence in mid-1987 when Humana, Inc., purchased an insolvent Florida HMO that had a history of violations of Medicare requirements. Although the Humana Florida plan has corrected many of these problems, HCFA found in early 1989 that the plan was violating Medicare requirements in four areas: marketing, claims payment, processing of beneficiary appeals, and implementation of an internal quality assurance system. HCFA required two or more years to correct deficiencies in the marketing and quality assurance areas, and has not corrected claims payment and beneficiary appeals deficiencies. During this period of violations, the Humana Medical Plan enrolled over 125,000 new Medicare beneficiaries.

Problems of the nature HCFA identified at the Humana plan can have significant adverse effects on beneficiaries' out-of-pocket costs or on their access to and quality of care. To help prevent the recurrence of such problems, HCFA needs to unequivocally establish both its authority and intention to take timely and decisive action against HMOs that violate Medicare's minimum beneficiary safeguard standards. HCFA can do so by finalizing its sanction regulations, devising and publishing standards necessary to enforce its requirements, and developing policies regarding when it will stop requesting organizations to correct violations and impose a sanction.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss our recent review of federal efforts to address violations of Medicare requirements at the Humana Medical Plan, Inc., which is located in Florida.[1] Recently, concerns over federal oversight of Health Maintenance Organizations (HMOs) were rekindled by press articles alleging widespread problems with Humana Medical Plan, which is Medicare's largest HMO contractor. The articles reported allegations of marketing and claims payment abuses by this contractor and also problems relating to its quality of care.

In light of these allegations, congressional requesters[2] asked us to review the actions of the Health Care Financing Administration (HCFA), which is responsible for overseeing HMOs serving Medicare enrollees. Specifically, they asked us to ascertain whether HCFA had identified the problems alleged by the press and whether HCFA's actions to resolve problems at Humana Medical Plan were prompt and effective.

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[1]Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

[2]Fortney H. (Pete) Stark, Chairman, Subcommittee on Health, House Ways and Means Committee, and Representatives Lawrence J. Smith and E. Clay Shaw.

RESULTS IN BRIEF

Our review illustrates, as did our prior work on this subject, that HCFA has not been effective in getting certain HMOs to take corrective actions promptly. The continued violations of Medicare requirements by Humana Medical Plan demonstrates HCFA's unwillingness and inability to enforce Medicare requirements on HMOs serving Medicare beneficiaries.

Although we determined that HCFA verified the problems identified in the press, HCFA has yet to resolve all the problems after nearly 3 years of effort. Specifically, HCFA found Humana Medical Plan to be violating federal standards related to four areas: marketing, claims payment, processing of beneficiary appeals, and implementation of an internal quality assurance system. Deficiencies in these areas can mean that beneficiaries incur high out-of-pocket costs or are denied appropriate care. In light of these consequences, we believe that allowing Humana Medical Plan to enroll over 125,000 new beneficiaries during its protracted period of noncompliance was unreasonable.

HCFA can and should have done more to require Humana Medical Plan to resolve its deficiencies. To help prevent the recurrence of sustained deficiencies, HCFA needs to unequivocally establish both its authority and intention to take timely and decisive

action against HMOs that violate Medicare's minimum beneficiary safeguard standards.

BACKGROUND

At this point, let me provide some background about this program. About 4 percent (1.4 million) of the nation's 33 million Medicare beneficiaries are enrolled in federally qualified risk HMOs. Such HMOs contract with HCFA to provide health care in return for a predetermined monthly payment per enrollee. HCFA typically makes site visits to these HMOs to monitor their compliance with Medicare requirements. If an HMO that is out of compliance does not carry out required corrective actions, HCFA can terminate the HMO's Medicare contract or, in some cases, suspend enrollment of additional Medicare beneficiaries or impose monetary penalties.

Humana Medical Plan accounts for about 15 percent of all Medicare beneficiaries enrolled in risk HMOs nationwide. Most of the health care provided by Humana Medical Plan is provided by subcontractors called affiliated providers. These affiliated providers are independent physicians or group practices. Because the Humana plan pays them a fixed amount per enrollee to provide health services, in many respects the affiliated providers operate like small HMOs.

Now, let me discuss in more detail the four problem areas HCFA identified at Humana Medical Plan.

MARKETING PRACTICES WERE
A HCFA CONCERN

The first area involves marketing practices. Humana Medical Plan violated Medicare requirements in this area for 2-1/2 years. HCFA first expressed internal concerns about marketing abuses in 1987, but it did not cite the Humana Medical Plan for violating Medicare standards in this area until 1989. At that time, HCFA found the plan to be violating the requirement to provide members with current information on the plan's rules, benefits, and costs. Violation of this requirement can result in costly misunderstandings in which, for example, enrollees could incur charges for expensive medical services that are not covered by the HMO plan.

In early 1990, marketing practices at another HMO owned by Humana led HCFA to investigate marketing practices at five of the six Medicare risk plans that Humana owns. The investigation led HCFA to characterize Humana as having a corporate philosophy of aggressive and manipulative marketing practices.

According to HCFA, this philosophy was expressed most explicitly in Humana's corporate marketing training manual, which

recommended, for example, that marketing agents employ a tactic called the "kleenex close." This tactic involves obtaining the enrollment of reluctant customers by manipulating them to gain their sympathy. Marketing agents who fail to make a sale remark to their customers, upon leaving, that their livelihood depends on these sales and that they need to learn from the experience of losing a sale. They ask the customer to specify what information was not properly covered so that they can avoid repeating the mistake in the future. The agent is then advised to " . . . cover it and close [the sale]!" HCFA requested that Humana revise its marketing guidance to eliminate these practices.

In October 1991, HCFA reported Humana Medical Plan in compliance with marketing requirements.

HCFA IDENTIFIED RECURRING PROBLEMS WITH PAYMENT OF CLAIMS

Inappropriate denial or delayed payment of claims is another area where HCFA found problems over the last 3 years. These problems at Humana Medical Plan have not yet been fully corrected.

In its three site visits since 1989, HCFA found that Humana Medical Plan denied certain types of claims for inappropriate reasons. The plan refused to pay claims for emergency services

and for urgently needed services obtained outside the plan's service area because the plan had not authorized the services in advance. Denying payment for such claims is a violation of Medicare regulations. The regulations require risk HMOs to pay for services delivered outside the HMO's service area if they meet Medicare's criteria for emergency or urgently needed services. HCFA found in 1991 that the plan's affiliated providers were still denying payment for the physician portion of some emergency hospital stays, even though the plan had approved payment for the hospital portion.

The effects of this on beneficiaries can be significant. For example, in one case, a Medicare enrollee was admitted to a hospital on an emergency basis. On the grounds that this admission had not been authorized by a Humana plan physician, the Humana plan refused to pay for it. This left the beneficiary with an unpaid $24,000 hospital bill. Eventually, the hospital asked HCFA to intervene, and 16 months after the beneficiary was discharged, the Humana plan reversed its position and paid for the admission.

Though inappropriate denials such as this are a serious problem, HCFA has not developed standards that define the percentage of inappropriate denials it will tolerate. Without such standards, HCFA determined that it could not consider the

HMO as violating a Medicare requirement. Concerned about this problem, HCFA is now beginning to develop such standards.

In addition to inappropriate denials, HCFA has also found Humana Medical Plan to be slow in paying its bills. Since early 1989 HCFA has continued to find that some of the plan's affiliated providers fail to pay bills within required time limits for services given by outside providers.

HCFA HAS NOT FORCED HUMANA PLAN TO CORRECT VIOLATIONS IN HANDLING BENEFICIARIES' APPEALS

A third problem involves Humana Medical Plan's process for beneficiaries to appeal claims. Medicare has established specific criteria and time frames that HMOs must meet for handling beneficiary appeals. Medicare regulations also require HMOs to send cases not resolved in the beneficiary's favor to HCFA for a final decision. HCFA found that Humana Medical Plan did not follow these requirements. Specifically, when beneficiaries complained that the plan inappropriately denied their claims, the plan did not always treat these complaints as Medicare appeals. This treatment has the effect of denying beneficiaries their right to appeal to HCFA. In fact, these beneficiaries may find themselves liable for large medical bills with recourse only through the courts, which many may find too costly and unfamiliar to use. A 1991 HCFA monitoring report

specifically noted the similarity between the beneficiary appeals deficiencies found in 1991 and those found in 1989.

HCFA AWARE OF PERSISTENT PROBLEMS WITH QUALITY ASSURANCE

Quality assurance is another area where HCFA found violations. In 1989 HCFA found that Humana Medical Plan did not, as regulations require, collect enough ambulatory care data to systematically identify individual physicians with patterns of underservice to Medicare enrollees. The plan did not resolve this problem until 2 years after HCFA requested corrective action.

Medicare's system of paying HMOs encourages them to be cost conscious. They are paid a predetermined rate per enrollee, and HMO providers may strive not to exceed the fixed amount by "underserving," or providing fewer services to enrollees than are necessary. The Florida Peer Review Organization has found instances of such underservice at Humana Medical Plan. Since 1987 the Organization has identified at least 35 physicians with patterns of underservice to Medicare enrollees. These patterns included failure to order appropriate diagnostic tests and failure to follow up on abnormal test results.

HCFA was particularly concerned about the lack of data on physicians' service patterns because of an inherent incentive for Humana Medical Plan affiliates to underserve Medicare enrollees. That is, Humana Medical Plan passes on to its affiliated providers a significant portion of the financial risks it assumes from Medicare. Specifically, the affiliates are at risk for 50 percent of losses incurred for hospital inpatient care (subject to a $20,000 dollar per hospitalization stop loss provision) and 100 percent of losses incurred for outpatient primary care. In its 1989 site visit report, HCFA said these arrangements made it imperative that Humana Medical Plan develop a system to routinely monitor primary and specialty ambulatory care services.

HCFA'S EXISTING SANCTION AUTHORITY REMAINS UNUSED

Lastly, I would like to discuss HCFA's authority to impose sanctions on HMOs that fail to comply with Medicare requirements. Almost 4 years have passed since the Congress gave HCFA the authority to impose intermediate sanctions that are less drastic than contract termination. Under the 1987 Omnibus Budget Reconciliation Act, HCFA may assess civil monetary penalties or suspend the enrollment of Medicare beneficiaries. HCFA officials have been reluctant to use this authority because final regulations have not been issued. Draft regulations were published for comment about 4 months ago. However, even when

final regulations are published, HCFA's use of the intermediate sanctions may be impeded by a lack of policy guidance on the types of circumstances that warrant the sanctions. Lack of such policy guidance has already been a source of conflict between regional and headquarters HCFA personnel. Consequently, HCFA needs to formulate such policy guidance.

As we reported in 1988 and in 1991, HCFA's authority to impose intermediate sanctions does not apply in every circumstance under which an HMO might be violating Medicare requirements.[3] The sanctions apply when an HMO fails to pay provider bills in a timely fashion, fails to provide required medically necessary items and services, or misrepresents or falsifies information provided to the Secretary or to other individuals and entities.

We recommended in 1988 that Congress consider giving HCFA broader authority so that HCFA could more easily apply intermediate sanctions. Specifically, we recommended that HCFA be given greater discretion to suspend Medicare enrollments in HMOs that, for whatever reason, fail to respond to notices concerning violations in a timely manner or have recurring deficiencies.

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[3] Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988); Medicare (GAO/HRD-92-11, Nov. 12, 1991).

CONCLUSIONS

In conclusion, the Humana Medical Plan case illustrates that HCFA has not yet corrected the longstanding problems it has in obtaining corrective action from HMOs. To become more effective, we believe HCFA should take two actions. Specifically, HCFA should

- -- adopt policies for determining the circumstances that warrant intermediate sanctions, and
- -- develop a standard for HMOs that would specify an acceptable performance rate for paying claims.

Lastly, broadening HCFA's sanction authority along the lines that we recommended in our 1988 report could help avert future problems by making any violations of Medicare requirements by an HMO subject to intermediate sanctions.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.