United States General Accounting Office 143353

GAO

Testimony

143353

For Release
on Delivery
Expected at
10:00 a.m. EST
Wednesday
March 13, 1991

MEDICARE: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs

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Before the
Special Committee on Aging
United States Senate

GAO/T-HRD-91-12

GAO Form 160 (12/87)

050797/143353

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the results of GAO's evaluation of the effectiveness of peer review organizations (PROs) in assessing the quality of care at health maintenance organizations (HMOs). We did this study at the request of Senator John Heinz, ranking minority member of this Committee, and our final report is being released today.[1] This testimony summarizes the report's findings, conclusions, and recommendations.

After almost 4 years of operation, the PRO review program has not provided the intended assurance that Medicare beneficiaries enrolled in risk HMOs are receiving quality health care. The program's effectiveness has been impeded by a lack of strong central management from the Health Care Financing Administration (HCFA).

First, HCFA has no assurance that internal quality assurance programs at most HMOs are effectively identifying and correcting quality-of-care problems. HCFA made PRO review of these important HMO programs optional, and most HMOs elected not to have their quality assurance activities reviewed by the PROs.

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[1] Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Further, the PRO external medical records review has not provided a valid assessment of the quality of care at risk HMOs because the PROs have not had access to comprehensive HMO data from which to select their review samples. Finally, HCFA has not used the PRO review results--from the assessment of HMO quality assurance programs or medical records review--in its own HMO compliance monitoring process.

HCFA has recently proposed a new PRO review methodology and believes that it will correct some of the problems identified in our study. However, we have a number of concerns about HCFA's proposal. Most importantly, we do not believe it addresses the underlying data problems that have hampered the PRO/HMO review program from the outset.

BACKGROUND

Most Medicare beneficiaries receive their care in the fee-for-service sector of the health care system. In that sector, most inpatient hospital and hospice care is paid on the basis of prospectively determined rates, and skilled nursing facilities and home health agencies are paid on the basis of cost. Part B services are paid on a reasonable charge basis or, as in the case of laboratory and anesthesiology services, on a fee schedule basis.

About 2 million Medicare beneficiaries are enrolled in HMOs and Medicare pays HMOs in one of two ways for all covered services. First, they may be paid for the actual cost of caring for the Medicare beneficiaries enrolled in the plan. The payment is estimated in advance on the basis of the HMO's experience, and adjusted retroactively to reflect actual allowable costs.

Alternatively, if the HMO meets certain conditions, it can enter into a risk contract with Medicare. Under risk contracts, HMOs agree to provide all covered health care services to enrolled Medicare beneficiaries in return for a fixed payment per enrollee. This payment system (called capitation) gives HMOs the incentive to be cost efficient and avoid unnecessary care. But it may also represent a potential threat to quality care by encouraging inappropriate reductions in services.

HCFA, as the federal agency responsible for managing Medicare, has to balance its efforts to contain program costs by increasing beneficiary enrollment in risk HMOs with its responsibility to ensure that beneficiaries receive quality health care. HCFA reviews the HMOs to determine if they are structured to comply with certain regulatory requirements, such as having an internal quality assurance program that is capable of identifying and correcting quality of care problems.

To augment HCFA's HMO oversight activities, the Congress mandated that HCFA contract with PROs for an external medical assessment of the quality of care provided by risk HMOs on or after April 1, 1987. To make this assessment, the PROs review samples of HMO medical records related to both inpatient hospital and outpatient (ambulatory) care provided to Medicare enrollees.

HCFA HAS NOT EFFECTIVELY USED PROs TO ASSESS HMO QUALITY ASSURANCE PROGRAMS

Health care providers have the primary responsibility for assuring quality. For institutional and group providers--such as hospitals, home health agencies, and HMOs--an internal quality assurance program (QAP) can be instrumental in carrying out this responsibility. We believe that it is particularly important that risk HMOs have an effective internal QAP. Thus, a comprehensive program for federal oversight of quality of care provided to Medicare HMO enrollees should begin with an evaluation or validation of the HMOs' internal QAPs.

HCFA could have used the medical expertise of the PROs to review QAPs in a way that complemented its own structural reviews of the HMO programs. Instead, it made the PRO review of QAPs optional on the part of the HMOs. Only 57 of the 204 risk HMOs that have participated in the Medicare program have had their internal QAP reviewed by the PROs.

The PROs determined that 36 of the 57 QAPs reviewed were unable to identify and correct quality-of-care problems. The results of the PRO evaluations suggest that these QAPs had weaknesses that may have violated federal regulations. For example, the PROs found that the quality assurance programs at 10 HMOs did not have physicians or other health professionals reviewing delivery of services.

HCFA generally has not used the results of the PRO QAP assessments in its own compliance monitoring process and has not required the HMOs to take corrective action on the PRO-identified deficiencies. HCFA officials told us that they followed up on only 1 of the 36 deficient QAPs. The reason cited was concern about the validity of the findings stemming from the lack of uniformity in the PRO review process. We do not find this reasoning compelling.

PRO EXTERNAL REVIEW DOES NOT ASSURE THE QUALITY OF CARE PROVIDED BY RISK HMOS

The PRO external reviews, which began in 1987, were intended to strengthen HCFA's oversight by providing a systematic medical evaluation of the care provided by risk HMOs. This program's success, however, was jeopardized from the outset because the PROs have not had access to comprehensive HMO data

from which to draw valid review samples. Difficulties experienced by the PROs in attempting to review inpatient hospital care help illustrate this problem.

To make a valid assessment of the quality of inpatient hospital care, PROs should select their review samples from a complete listing of HMO enrollees who have been hospitalized. PROs must also be able to determine the dates of the inpatient hospital stays and the conditions treated. Many HMOs, however, do not have the management information systems capable of providing PROs with this information. Thus, PROs have yet to conduct enough reviews to accurately assess the care provided to Medicare enrollees.

HCFA's efforts to resolve the sampling problem over the past several years have not addressed the underlying data issue. Rather, they have focused on the form used to capture the needed inpatient information and the question of who should be responsible for submitting it to the PROs--HMOs, hospitals, or fiscal intermediaries.

HCFA'S PROPOSED SAMPLING PLAN MAY NOT IMPROVE PRO/HMO REVIEW

HCFA recently released a proposal to reform the PRO/HMO review methodology. Under this proposal, the PRO will select a

sample from the list of enrollees provided by HCFA and then ask each HMO to determine if the selected enrollees received treatment during the previous six months. For enrollees who have, the HMO will be expected to obtain the medical records (from the hospitals or the physicians) and provide them to the PRO. If necessary, the PRO will return to the original list and select additional enrollees to replace those not receiving health care services.

We have a number of concerns about the proposal. Most importantly, the proposed methodology will be affected by the same basic problem that has hampered the current PRO/HMO review process--the lack of centralized HMO information on enrollees receiving either inpatient or ambulatory care. If HMOs maintained such information currently, there would be no need to change the PRO sampling and review methodology.

Under this proposal, many HMOs will be required to contact participating providers to determine which of the enrollees selected for review have received services and the type of services provided. This could be especially problematic in independent practice association model HMOs because of the number and dispersion of the physicians involved.

We are also concerned that the proposed sampling methodology would not allow PROs to focus on specific high-risk medical

conditions or procedures. In describing the proposed changes, HCFA acknowledges that the current PRO/HMO review methodology, using specific review categories, appears to be "more effective in identifying specific problems" than a process that uses randomly-selected enrollees. The proposal also seems inconsistent with impending changes to the PRO review of fee-for-service health care that will use objective criteria to target problem areas for review.

In summary, we believe that the proposed short-term change to the PRO/HMO review methodology--like the numerous changes that have preceded it--reflects HCFA's inability to address the underlying data problems which have hampered this review program from the outset. We question how HMOs can continue to meet statutory and regulatory requirements for Medicare participation if they are unable to provide PROs with the basic information required to select their review samples. The Public Health Service Act requires each participating HMO to develop a "health (including medical) record keeping system through which pertinent information relating to the health care of the patient is accumulated and is readily available to appropriate professionals". Further, federal regulations require risk HMOs to have a quality assurance plan which uses "systematic data collection" to identify patterns of suspected aberrant care, such as withholding necessary services.

HCFA has established a long-term goal of fostering the development of a standardized clinical data set by which HMOs will report beneficiary-specific service information. However, it may be several years before such data is available. Thus, we believe that in the short term, HCFA should attempt to make the PRO/HMO review program work as intended by enforcing existing HMO data requirements.

CONCLUDING REMARKS

Our report makes a number of recommendations for improving HCFA's oversight of risk HMOs through more effective use of PROs. For example, we believe that HCFA should amend the HMO and PRO contracts, at the earliest opportunity, to make mandatory the PRO review of QAPs of all risk HMOs participating in the Medicare program.

Concerning the data problems that have impeded the PRO review effort, we believe that HCFA should (1) identify the minimum inpatient and ambulatory data needed by PROs to draw their review samples, (2) work with HMOs to determine the most efficient way of collecting and maintaining this information centrally, and (3) ensure that HMOs are complying with regulatory and contractual data requirements.

We are also recommending that the Congress amend the Social Security Act to give HCFA explicit authority to impose remedies--such as suspending enrollment or payments or imposing civil monetary penalties--to help assure that risk HMOs comply in collecting and submitting the inpatient hospital information needed by the PROs to carry out their review responsibilities.

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Mr. Chairman, this concludes my prepared statement. My colleagues and I will be pleased to answer any questions you and the other members of the Committee may have.