

GAO

Report to the Chairman, Subcommittee  
on Health and the Environment,  
Committee on Energy and Commerce,  
House of Representatives

May 1993

# MEDICAID

## HealthPASS: An Evaluation of a Managed Care Program for Certain Philadelphia Recipients



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General Accounting Office  
Washington, D.C. 20548

**Human Resources Division**

B-252699

May 7, 1993

The Honorable Henry A. Waxman  
Chairman, Subcommittee on Health  
and the Environment  
Committee on Energy and Commerce  
House of Representatives

Dear Mr. Chairman:

In response to your request, we have reviewed certain aspects of the Philadelphia Accessible Services System (HealthPASS). We found that (1) women who avail themselves of pregnancy-related care are receiving appropriate services, (2) some providers are not furnishing preventive care services to children as federally mandated, and (3) enrollment of eligible HealthPASS members in the Special Supplemental Food Program for Women, Infants, and Children (WIC) is no greater than the enrollment of eligible Medicaid fee-for-service women and children. However, if the names of HealthPASS members were shared with the WIC contractor, enrollment could increase. We also found that the HealthPASS quality assurance program meets federal and state standards, but its physician credentialing program could be improved if additional information about physician sanctions were sought. We have made specific recommendations about sharing the names of HealthPASS members with the WIC program and improving HealthPASS's physician credentialing procedure.

In response to physician concerns and competitive pressures, the HealthPASS administrator recently revised its physician incentive program. It is too early to determine the effects of these changes. However, previous incentive arrangements may have had an adverse impact on access to specialty care.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the appropriate congressional committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. We also will make copies available to others on request.

This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. Should you have any questions, please call him at (202) 512-7101. Other major contributors are listed in appendix X.

Sincerely yours,

Lawrence H. Thompson  
Assistant Comptroller General

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# Executive Summary

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## Purpose

Federal and state policymakers believe that managed care programs are a less expensive alternative to the traditional fee-for-service medical system.<sup>1</sup> However, critics have warned that managed care's use of capitation rates<sup>2</sup> and financial incentives to control costs could impede patients' access to necessary treatment and diminish the quality of health care. In 1986, the state of Pennsylvania contracted with several private companies to offer managed care to all Medicaid recipients,<sup>3</sup> approximately 115,000, living in south and west Philadelphia. The largest program is called the Philadelphia Accessible Services System—HealthPASS.

The Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked GAO whether HealthPASS members are receiving (1) timely and appropriate pregnancy-related services, (2) Early and Periodic Screening, Diagnostic and Treatment services (EPSDT), and (3) Special Supplemental Food Program for Women, Infants, and Children (wic) benefits. Also, the Chairman wanted to know if the program's financial incentive arrangements with primary care physicians could compromise the quality of care provided. GAO also agreed with the Chairman's office to review certain aspects of HealthPASS's quality assurance program and its credentialing process.

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## Background

Medicaid is a federally aided, state-administered program that finances health care for the nation's poor. Within the Department of Health and Human Services, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations. In an effort to provide more cost-effective care, the Congress passed legislation in 1981 that permitted states to develop alternative delivery systems for Medicaid recipients. In 1983, Pennsylvania decided to develop HealthPASS as a Medicaid alternative in Philadelphia.

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<sup>1</sup>Managed care programs are designed to reduce the number of unnecessary medical services provided to patients.

<sup>2</sup>A capitation rate is a fixed, prepaid, monthly payment based on the number of patients enrolled in a program or assigned to a provider. The rate often takes into consideration the age and sex of the patient as well. Frequency of visits and services provided have no effect on the reimbursement received.

<sup>3</sup>Approximately 76,000 Medicaid recipients are enrolled in the HealthPASS program. As of December 1, 1992, about 43,800 of these recipients were women and about 31,200 were children under the age of 21.

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Healthcare Management Alternatives (HMA), Inc., has administered HealthPASS since July 1989.<sup>4</sup> All Medicaid recipients living in specific Philadelphia areas are expected to enroll in this program or one of two health maintenance organizations (HMO).<sup>5</sup> The state pays HMA a negotiated capitation rate that is lower than what the state expects to pay per patient under the traditional Medicaid fee-for-service system. HMA, in turn, contracts with primary care physicians for a specified capitation rate per member to provide both direct care and refer members to other medical services as necessary. However, a portion of the monthly payment is withheld and retained by HMA in a referral services fund to pay for specialty care services recommended by the primary care physician.

Primary care physicians are given any money remaining in the specialty referral fund at the end of the year or they must replenish any deficit that arises unless they meet specified conditions. (See ch. 3.) Although obstetricians who care for HealthPASS members are considered specialists, they are not paid from primary care providers' specialty care fund if the member is referred early in her pregnancy. Further, obstetricians are reimbursed at Medicaid fee-for-service rates plus 10 percent.

A key feature in HMA's contract with the state is that HMA is expected to develop outreach programs focusing on leading causes of death in minority populations, maternal and infant health care initiatives, information and counseling for teenage unwed mothers, and teenage preventive care services. HMA also is expected to assure that care provided to members is appropriate. HealthPASS covers all pregnancy-related services, including prenatal examinations, tests, delivery, and care after birth (postpartum care). It also is to furnish EPSDT services such as physical exams; immunizations; lead poison screening; testing for sickle cell anemia; and vision, dental, and hearing services for children through the age of 20. WIC, funded by federal and some state governments, is a nutrition and educational program available to low-income pregnant, breastfeeding, and postpartum women as well as infants and children up to age 5.

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<sup>4</sup>HMA administers HealthPASS as a health insuring organization that coordinates but does not deliver health care services directly. The original HealthPASS administrator filed for bankruptcy in March 1989 forcing the state to pick a new administrator.

<sup>5</sup>The existing HMOs in the area when the HealthPASS contract was first established did not have the capacity to provide services to all targeted recipients.

## Results in Brief

Pregnant women enrolled in the HealthPASS program are receiving appropriate obstetrical care when they avail themselves of pregnancy-related services. However, most of the pregnant women in GAO's sample did not seek pregnancy-related care early or often enough despite HMA's outreach efforts to encourage HealthPASS members to obtain care. Further, GAO observed high rates of prematurity and low birth weight babies whether or not members received recommended levels of care. GAO also observed similar levels of infrequent care and poor birth outcomes in its medical record reviews of a sample of traditional Medicaid fee-for-service recipients. Both the HealthPASS and the Medicaid fee-for-service populations have a high incidence of alcohol, tobacco, and drug use and other health problems that result in poor birth outcomes. In addition, transportation or child-care problems make accessing pregnancy care particularly difficult.

Many children enrolled in the HealthPASS program are not receiving timely and federally mandated EPSDT services. Problems are occurring in the provision of immunizations, vision tests, hearing tests, and lead poison and sickle cell anemia screening. HMA studies indicate that the services are not being provided because (1) some physicians are not aware of EPSDT requirements and (2) parents and guardians are not scheduling their children for these services. Outreach programs and an increase in the reimbursement for these services have not yet yielded significant increases in the overall number of EPSDT services provided.

HMA actively encourages HealthPASS members to join the WIC program even though HMA is not contractually obligated to do so. However, these programs have not increased significantly the numbers of women and children enrolled. HMA does not share the names or identifying information of WIC-eligible HealthPASS members with the WIC contractor because of confidentiality concerns. However, HCFA officials believe that such information can be exchanged with the WIC state agency without violating an individual's privacy rights.

In January 1993, HMA revised its physician compensation program by increasing capitation rates and moderating the repayment program for specialty referral fund deficits. In return, primary care physicians agreed to accept all HealthPASS members appropriate for that physician's practice and to meet specific quality assurance and utilization review requirements. When, in the past, HMA has changed its financial incentive arrangements with providers and assumed greater financial responsibility for certain referrals, the result has been increased referrals by providers. This

suggests that the incentives may have affected decisions about the services patients receive, although the evidence is inconclusive.

Several reviews of HMA's quality assurance program have shown that it meets federal and state requirements.<sup>6</sup> GAO found, however, that HMA has unknowingly contracted with physicians whose performance is substandard or whose conduct is unprofessional. HMA could significantly increase its awareness of such situations by using information about physician sanctions and adverse actions available from the Federation of State Medical Boards and the National Practitioner Data Bank.

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## Principal Findings

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### Prenatal Care Provided Is Consistent With Obstetrical Guidelines but Not Actively Sought by Members

Pregnancy-related care provided to HealthPASS women when they seek it generally meets American College of Obstetricians and Gynecologists' (ACOG) guidelines. However, many women did not seek care in the first trimester of pregnancy, a critical period in the unborn baby's development, or return for care often enough during their pregnancy.<sup>7</sup> This situation occurred in spite of HMA's educational outreach programs, which are designed to encourage women to seek obstetrical care early and often in their pregnancy. Lack of motivation, transportation, and child care and little understanding of the importance of pregnancy-related care are among the reasons HMA believes pregnant women do not seek obstetrical care. The birth outcomes for the estimated 85 (25%) pregnant HealthPASS women whose care is classified as adequate resulted in about 21 babies being low birth weight, about 4 being very low birth weight, and about 13 being premature. The birth outcomes for the estimated 161 (48%) HealthPASS women whose care is considered intermediate resulted in about 17 babies being low birth weight babies and about 25 being premature. The birth outcomes for the estimated 93 (28%) HealthPASS women whose care is considered inadequate resulted in about 8 of the babies being low birth weight babies, about 13 being very low birth weight, about 51 being premature, and about 4 being stillborn.<sup>8</sup> However, poor outcomes also are

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<sup>6</sup>In our report, *Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program* (GAO/HRD-88-37, Dec. 22, 1987), we found that key quality assurance mechanisms, such as internal peer review, were not in place.

<sup>7</sup>Using ACOG guidelines, the Institutes of Medicine developed a methodology that classifies care based on a patient's adherence to early and frequent prenatal care. These classifications—adequate, intermediate, and inadequate—are defined in chapter 2.

<sup>8</sup>These are estimated numbers; see appendix III for associated sampling errors.

the result of other risk factors, such as the use of tobacco, alcohol, or drugs. GAO's findings were similar for women who delivered under the traditional Medicaid fee-for-service system in Philadelphia, which does not feature an extensive outreach program. (See ch. 2.)

### Many Children Are Not Receiving EPSDT Services

Many children enrolled in HealthPASS are not receiving preventive care as professionally recommended or as federally mandated, leaving them susceptible to high-risk illness or irreversible or costly disabilities. The Joint Commission on Accreditation of Healthcare Organization's ongoing review of medical records shows that only some eligible HealthPASS children are receiving legally required EPSDT services, such as immunizations (62 percent), vision tests (48 percent), hearing tests (44 percent), lead poison screening (22 percent), or testing for sickle cell anemia (18 percent). HMA's medical reviews and studies indicate that some primary care physicians are not providing comprehensive EPSDT services because they are unaware of specific EPSDT requirements. HMA studies also suggest that parents and guardians may not be scheduling their children for these services because they might be confronted with transportation and child care problems and difficulties in scheduling appointments.

HMA is attempting to increase the provision of EPSDT services by giving parents immunization schedules, emphasizing childhood immunizations during the enrollment process, and discussing the importance of EPSDT services with parents during home visits. But, with the exception of hearing and vision screening, no substantial increase in the number of children receiving EPSDT services has been reported. HMA has taken steps to improve physicians' awareness of EPSDT screens and has implemented new outreach programs for parents, but these efforts are too new to evaluate. (See ch. 2.)

### HMA Informs Members About WIC, but Additional Measures Could Be Taken to Improve Enrollment

HMA is working through education and outreach efforts to encourage members to join the WIC program. These efforts are not a contractual obligation and are performed as a service to its membership. However, HMA's efforts have not increased the numbers of women and children enrolled in WIC beyond the rate found in the traditional Medicaid fee-for-service system. Approximately 74 percent of eligible HealthPASS women and 72 percent of HealthPASS children are enrolled in WIC. The numbers of women and children in the traditional Medicaid fee-for-service system enrolled in WIC are about the same—69 percent and 74 percent, respectively.



Enrollment of HealthPASS members in WIC could increase if the names of HealthPASS members were shared with WIC program officials and if WIC officials used this information in WIC's outreach efforts. The state and HMA agree. But no action has been taken because of a misunderstanding between the state, HMA, and HCFA regarding safeguarding the identity of Medicaid applicants and recipients. Under 42 U.S.C. 1396a(a)(11), Medicaid plans are required to coordinate with state WIC programs. With proper safeguards, HCFA believes that the state agencies responsible for administering the state Medicaid and WIC programs can devise an information exchange where recipient confidentiality can be preserved. (See ch. 2.)

**New Physician  
Reimbursement  
Arrangements Cannot Yet  
Be Evaluated**

HMA's financial incentive arrangements with primary care physicians are designed to control medical costs and reduce the likelihood that care provided to members will be limited inappropriately because physicians fear financial loss or seek financial gain. But HMA's previous financial incentive arrangements may have been reducing access to health care. In July 1991, HMA stopped charging the primary care physicians' specialist referral fund when a mammogram referral was made. During the next 6 months, the number of referrals increased between 2.5 to 3 percent, depending upon the age of the women.

On January 1, 1993, HMA again revised its financial incentive arrangements with physicians. The changes were made to address primary care physician complaints that they were not being adequately compensated for their services and HMA's concern that it was not competitive with other managed health care plans. The modifications also are aimed at reducing the likelihood that care provided members will be limited because physicians fear incurring a financial loss. Changes include increasing capitation rates, suspending repayment of referral specialty fund deficits, and eliminating any such deficit balances a physician may have at the end of the year if quality assurance and utilization review requirements are met. These requirements incorporate items such as submission of credentialing and encounter data and ordering appropriate referrals. The possible effects of these revised financial arrangements on health care quality cannot be determined at this time. (See ch. 3.)

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### HMA's Quality Assurance Approach Meets Federal and State Requirements, but Its Credentialing Program Needs Improvement

Several reviews of HMA's quality assurance program have shown that it meets federal and state requirements and contains provisions that go beyond those mandated by the state for the traditional Medicaid fee-for-service system. But HMA is unknowingly contracting with physicians who may be furnishing inappropriate care to HealthPASS members. The physician credentialing program is not identifying all HealthPASS physicians who have been sanctioned in states where they are licensed or by hospitals where they have practiced or have had malpractice claims paid on their behalf. For example, GAO found that 72 of the estimated 2,200 HealthPASS providers had malpractice claims paid on their behalf. These claims totaled at least \$40 million. More importantly, three physicians had sanctions taken against them. Some of this information can be purchased by HMA from the Federation of State Medical Boards. Additional information is in the National Practitioner Data Bank—a federally mandated nationwide clearinghouse for information on physicians with adverse actions or malpractice insurance judgments paid on their behalf. HMA, however, is excluded by title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660) from accessing the data bank. (See ch. 4.)

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### Matter for Congressional Consideration

The Congress may wish to consider amending title IV of the Health Care Quality Improvement Act of 1986, to require health insuring organizations to participate in the National Practitioner Data Bank. By doing so, health insuring organizations like HealthPASS could access information needed to identify unethical or incompetent practitioners.

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### Recommendations to the Secretary of Health and Human Services

GAO is recommending that the Secretary take actions to (1) require the Pennsylvania Department of Public Welfare and Department of Health to make the necessary arrangements to share the names of HealthPASS members with the WIC program and (2) direct the state to include in its contract with HMA a requirement to query nationwide information banks to improve the identification of potentially problematic physicians in the HealthPASS program. (See pp. 32 and 45.)

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### HMA, State, and HCFA Comments

We obtained written comments from HMA and the Pennsylvania Department of Public Welfare and oral comments from HCFA's Philadelphia Regional Office on a draft of this report. HMA made the overall comment that it may be years before HMA programs make a significant difference because of community problems relating to poverty, housing, and other

such issues. Generally, HMA agreed with our findings and recommendations, but believed that accessing the two physician data banks, as we recommended, might be duplicative. Therefore, it plans to pursue access to the National Practitioner Data Bank only. We disagree with HMA's plan. HMA should seek information from the Federation of State Medical Boards as soon as possible. Later, HMA should obtain information from the National Practitioner Data Bank if the Congress takes action to expand access to this data bank. Further, we believe access to both data files is needed because the scope of the two differ. (See pp. 44 and 45.)

The Pennsylvania Department of Public Welfare stated that much needs to be done to improve the use of prenatal care, pregnancy outcomes, and EPSDT screening and followup for children in both the HealthPASS and fee-for-service programs. But the Department took exception to GAO's use of Joint Commission criteria to determine HMA's compliance with EPSDT requirements. It pointed out that the Joint Commission's review showed only whether an event occurred or did not occur, not whether treatment should or should not have been provided. Also, the department believes that GAO should have determined what differences exist between fee-for-service and HealthPASS preventive care patterns rather than compare HealthPASS's EPSDT screening rates to the federal requirement. GAO disagrees, believing that the Joint Commission's criteria are appropriate and that federal law is the correct basis against which to gauge HealthPASS's success. (See p. 45.)

HCFA's regional officials told us that names and other identifying information about HealthPASS members cannot be shared with WIC providers. However, HCFA agrees that this information can be shared with the WIC state agency by state officials responsible for the HealthPASS program. (See p. 45.)

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Abbreviations

ACOG	American College of Obstetricians and Gynecologists
AIDS	acquired immunodeficiency syndrome
CEO	Chief Executive Officer
C.F.R.	Code of Federal Regulations
DTP	diphtheria, tetanus, and polio
EPSDT	Early and Periodic Screening, Diagnostic and Treatment services
HCFA	Health Care Financing Administration
HealthPASS	Philadelphia Accessible Services System
HMA	Healthcare Management Alternatives, Inc.
HMO	health maintenance organization
WIC	Special Supplemental Food Program for Women, Infants, and Children



# Introduction

Managed health care programs have been suggested by some federal and state policymakers as a strategy for providing health care at a lower cost for Medicaid recipients.<sup>1</sup> However, other policymakers and advocates for Medicaid recipients are concerned that under such a system recipients could be underserved and the quality of health care compromised because providers may limit services. Recognizing this possibility, some states have established managed care programs with safeguards to ensure that necessary care is provided in a timely manner. One such program is the Philadelphia Accessible Services System (HealthPASS), which the state of Pennsylvania implemented for approximately 115,000 Medicaid patients living in certain Philadelphia neighborhoods.

To help assess whether a program such as HealthPASS is appropriate for other state Medicaid programs, the Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked us to determine the extent to which HealthPASS is providing Medicaid recipients with needed primary and preventive care and whether the care provided is adequate.<sup>2</sup> Specifically, the Chairman asked us to determine whether HealthPASS members are (1) receiving prenatal care and other pregnancy-related services to which they are entitled in a timely and appropriate manner, (2) receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and any necessary follow-up treatment, and (3) being enrolled in the Special Supplemental Food Program for Women, Infants, and Children (wic). The Chairman also wanted to know if the program's financial incentive arrangements, particularly with primary care physicians, have the potential to compromise the quality of care provided. We also agreed to review certain aspects of HealthPASS's quality assurance program and its credentialing process.<sup>3</sup>

## Medicaid

Medicaid is a federally aided, state-administered medical assistance program serving about 30 million low-income people in the United States.

<sup>1</sup>Managed care programs, such as a health maintenance organization, may use one or more utilization management strategies to ensure that only necessary services are provided to patients. The strategies include (1) reviewing and intervening in decisions about health services to be provided, (2) limiting or influencing patients' choices of providers, and (3) negotiating payment terms with providers.

<sup>2</sup>The Chairman, in May 1991, also asked the Inspector General (IG), Department of Health and Human Services, to review several issues surrounding the HealthPASS administrator's profits. A report was submitted to the Chairman by the IG on November 24, 1992, but its public release was restricted because it contains proprietary information.

<sup>3</sup>In our report, *Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program* (GAO/HRD-88-37, Dec. 22, 1987) we found that key quality assurance mechanisms, such as internal peer review, were not in place.



The Department of Health and Human Services administers Medicaid at the federal level. Within the Department, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations. Guided by broad federal limits, states set the scope and reimbursement rates for the medical services offered and make payments directly to the service providers. Depending on the state's per capita income, the federal government pays from 50 to 83 percent of the Medicaid costs for health services in a given fiscal year. In fiscal year 1992, Medicaid payments in Pennsylvania were about \$4.4 billion. The federal share was about 48 percent of this amount. For Philadelphia, Medicaid payments were \$1.3 billion. Of this, \$211 million is for the HealthPASS contract.

Traditionally, the Medicaid program pays individual providers a fee every time they perform a service. However, this approach has contributed to escalating Medicaid costs. In an effort to provide more cost-effective care, the Omnibus Budget Reconciliation Act of 1981 authorized the states to develop alternative delivery systems for Medicaid recipients. In 1983, the state of Pennsylvania decided to develop HealthPASS as an alternate to the fee-for-service system for serving the needs of the Medicaid population in a specific area of Philadelphia.

## HealthPASS

HealthPASS, which began in March 1986, is a Medicaid-only prepaid managed care health program currently serving about 76,400 Medicaid recipients in south and west Philadelphia. Of these recipients, about 43,800 are females and about 31,200 are children under the age of 21. Almost 13,000 of the children are under 5 years old. The HealthPASS service population is 77 percent African American, 17 percent white, 5 percent Asian, and 1 percent Hispanic. Because many of the residents of this area are poor, they are at higher risk for serious health problems. Infant mortality, acquired immunodeficiency syndrome (AIDS), cardiovascular disease, cancer, and substance abuse are prevalent.

Medicaid recipients living in HealthPASS neighborhoods must select and enroll in either HealthPASS or one of two health maintenance organizations (HMO) within the geographic area.<sup>4</sup> If HealthPASS is chosen, the new member is asked to select a physician to provide primary health care. If the member does not make a selection or is unsure who to select, an HMA

<sup>4</sup>The existing HMOs in the area when the HealthPASS contract was first established did not have the capacity to provide services to all targeted recipients.

employee working in the county assistance office helps by pointing out factors, such as the distance of the providers' office to the member's residence. Except for emergency care and a few other health services, such as family planning and outpatient mental health treatment, HealthPASS members must go through their primary care physician to obtain access to other services. Primary care physicians coordinate patient treatment and authorize referrals to specialists, including obstetricians and for hospital admissions. The two HMOs serving the HealthPASS area also provide health care services in a manner similar to HealthPASS. In contrast, under the traditional fee-for-service system in Pennsylvania, Medicaid recipients may change doctors without notice and self-refer to a specialist. Prior authorization is required for all elective surgery and certain dental services and medical equipment.

The Pennsylvania Department of Public Welfare designed the HealthPASS program to save about 10 percent—approximately \$23.2 million in calendar year 1991—of the annual fee-for-service cost of serving Medicaid recipients living in the area. Each year the state and the HealthPASS administrator negotiate the fixed percent of the projected fee-for-service costs for HealthPASS members that is to be paid to HMA for administration of the HealthPASS program. This fee is paid the administrator for each member enrolled in the program. Pennsylvania Department of Public Welfare officials estimate that from July 1989 through December 1991 HealthPASS saved the state about \$26.3 million and saved the Federal government about \$15.1 million. For 1992, the State is projecting state and federal savings of \$15.2 million and \$9.5 million, respectively.<sup>5</sup>

In July 1989, Healthcare Management Alternatives, Inc. (HMA), a private corporation, was selected by the state as the HealthPASS administrator.<sup>6</sup> HMA administers the program as a health insuring organization. As such, it coordinates but does not deliver health care services directly. Instead, HMA contracts with providers, such as physicians and hospitals, to furnish direct medical services. As a health insuring organization, HMA assumes financial responsibility for the health care of its members in exchange for the negotiated fixed, prepaid monthly payment—the capitation rate—for each member. If the costs of providing Medicaid services exceed the fixed

<sup>5</sup>Although the federal government's share in the Medicaid program is about 57 percent, its share in program savings is less than this because many HealthPASS members qualify only for Pennsylvania's general assistance program—a program for which the federal government does not pay matching funds. We did not verify the savings claimed by the Pennsylvania Department of Public Welfare.

<sup>6</sup>The Penn Health Corporation, a subsidiary of Maxicare, was the original HealthPASS administrator. In March 1989, Maxicare, including Penn Health, filed for bankruptcy. This action forced the state to seek a new program administrator.

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monthly payment, HMA incurs a loss. However, HMA has purchased reinsurance to protect itself against this possibility.<sup>7</sup> Conversely, if the costs of providing services is less than the contracted rate, HMA retains the profits.

HMA pays primary care providers a capitated rate based on the age and sex of each member assigned to that provider. However, a portion of the monthly payment is withheld and retained by HMA in a referral services fund to pay for specialty care services recommended by the primary care physician. With some exceptions, each time the primary care physician refers a patient for specialty care, his or her referral services fund is charged for the office visits along with any procedures or tests performed or ordered by the specialist. However, primary care physician's specialty referral accounts are not charged for prenatal care if the member is referred early in her pregnancy. If the referral occurs late in a woman's pregnancy, no charge is made against the fund if the referral is made to a special program designed for treating women in the later stages of pregnancy. Further, obstetricians, considered specialists, are reimbursed at Medicaid fee-for-service rates plus 10 percent.

Before July 1991, a primary care physician was financially responsible or at risk for up to \$4,000 per member for services billed by specialists. In July 1991, a limit of \$1,000 per patient was established as the total amount that the primary care physician would be at risk of repaying if the threshold was exceeded. This change in liability was not accompanied by any limits in the amount of specialty services primary care physicians could recommend. At the end of the contract year, any surplus in the physician's referral fund is paid to the physician. And, until January 1993, if the referral fund had a deficit, HMA deducted up to 20 percent of future monthly capitation payments until the deficit was recovered.

Since HMA became responsible for the HealthPASS program, a hospital management fund has been maintained to pay for member hospital care. For each member assigned to a physician, an amount based on age, sex, and Medicaid category is paid monthly by HMA into the hospital fund. No portion of the primary care physicians' capitation payment goes toward the hospital fund and primary care physicians are not financially at risk for hospitalizations. But they can earn additional money if overall hospital utilization has been favorable and there is a surplus in the hospital fund at

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<sup>7</sup>Reinsurance is a contract under which one or more insurer agrees to indemnify another with respect to all or partial losses. HMA's reinsurance policy provides for coverage if HMA's aggregate claims costs exceeds 100 percent of expected claims costs, to a maximum of \$23 million in the aggregate.

the end of the year. However, there has never been a surplus in this fund and no additional money has been paid to providers.

In January 1993, HMA implemented new provider incentive arrangements because physicians were dissatisfied with their compensation and HMA determined it was not competitive with other HMOs in their service area. Primary care physician financial liability for specialty referral services still remains but payback of referral fund deficits have been postponed until December 31, 1993. Forgiveness of any deficit balance is possible at that time if specific quality assurance and utilization review requirements are met. These requirements include the submission of credentialing and encounter data and the ordering of appropriate referrals.

HMA is responsible contractually for assuring that care provided to members is appropriate and for implementing an effective recipient education and outreach program. The state expects this program to include (1) a health education program focusing on leading causes of death, including infant mortality; (2) maternal and infant health initiatives; (3) a health education program for unwed teenage mothers; and (4) a health care awareness campaign aimed at HealthPASS teenagers that stresses the importance of preventive health care.

## Scope and Methodology

To evaluate pregnancy-related care, we drew a statistical sample of 80 HealthPASS women from a population of 338 who gave birth between April 1, 1990, and June 30, 1991, and were continuously eligible for Medicaid benefits during their pregnancy and postpartum care period. We hired a consultant<sup>8</sup> to review the health care provided the women in our sample based on information summarized from photocopied medical records furnished to us by HealthPASS.<sup>9</sup> Our consultant used guidelines developed by the American College of Obstetricians and Gynecologists (ACOG)<sup>10</sup> to assess the care provided. These guidelines are recommendations rather than a body of rigid rules. They are intended to be adapted to many different situations, taking into consideration patient needs, locality, institution, and the type of provider practice.

<sup>8</sup>Our consultant is an obstetrician and professor in obstetrics and gynecology with 36 years experience. In addition to his medical school responsibilities, he currently directs a high-risk women's clinic.

<sup>9</sup>We contracted with a certified perinatal registered nurse with 13 years obstetrical experience to perform this work. She currently works as a perinatal nurse coordinator at a perinatal intensive care center.

<sup>10</sup>ACOG is a private, voluntary, nonprofit organization of 33,000 obstetricians and gynecologists that develops and evaluates guidelines that broadly define acceptable women's health care.

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In addition, we used the Institute of Medicine Prenatal Care Index,<sup>11</sup> to determine the timeliness and frequency of prenatal care received from HealthPASS providers. This methodology is based on the patient's scheduling and keeping obstetrical visits as recommended by her provider rather than evaluating the quality and appropriateness of the medical care received during the obstetrical visit.

Since HealthPASS uses an outreach program to encourage members to seek early prenatal care, we compared the results of our evaluations with the results from a statistical sample of 80 Medicaid fee-for-service patients from a population of 1,932 pregnant women who were not involved in HealthPASS's outreach program to determine if there was a difference in either the appropriateness, timeliness, or frequency of care, or a difference in birth outcomes. We used the same methodology to select the sample and evaluate care and outcomes.

From the sample results, we estimated the percentage of women in the HealthPASS and Medicaid fee-for-service populations who received appropriate and timely care and the percentage of women delivering low birth weight, very low birth weight, premature, and stillbirth babies. These estimates are provided throughout the report.

Estimates derived from a statistical sample have an associated sampling error. A sampling error measures the precision of the estimate; the smaller the error, the more precise the estimate. Sampling errors have an associated confidence level that measures the probability that the estimate accurately describes the population. We calculated our sampling errors at the 95-percent confidence level. This means that the chances are about 95 out of 100 that the actual population percentage (or number) being estimated falls within the range given by our estimate, plus or minus the sampling error. Sampling errors differ for each sample size and sample result. Sampling errors for HealthPASS and Medicaid fee-for-service estimates are reported in appendix II and III.

To assess whether children are receiving EPSDT services, we reviewed the results of almost 18,000 medical record reviews conducted by the Joint Commission on Accreditation of Healthcare Organizations.<sup>12</sup> We also

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<sup>11</sup>"Infant Death: An Analysis by Maternal Risk and Health Care," *Contrasts in Health Status*, Vol. 1, Institute of Medicine, D.M. Kessner, ed. (Washington, D.C.: National Academy of Sciences, 1973), pp. 58-59.

<sup>12</sup>The Joint Commission is a national, private not-for-profit organization with expertise in establishing quality assurance standards.

(1) reviewed WIC enrollment data, (2) analyzed HealthPASS financial arrangements with primary care physicians, (3) examined HealthPASS's quality assurance plans and programs, and (4) examined HMA's education and outreach programs. To determine the thoroughness of HMA's physician credentialing process, we matched names contained in the National Practitioner Data Bank<sup>19</sup> and Federation of State Medical Boards' files for certain provider names. Further, we discussed the HealthPASS program with HealthPASS physicians and community groups and organizations to obtain their views on the program.

Our work was done at the Pennsylvania Department of Welfare in Harrisburg, Pa.; HMA, the current HealthPASS administrator in Philadelphia; and the HCFA regional office in Philadelphia. We reviewed reports and evaluations prepared by the Joint Commission, another independent assessor hired by the state of Pennsylvania to assess HMA's performance, and others. We held discussions with officials at ACOG and the American Academy of Pediatrics regarding standards of care for pregnant women and children. We also talked with health education professionals regarding HealthPASS's education and outreach programs.

We provided HCFA, the Pennsylvania Department of Public Welfare, and HMA with a copy of our draft report and discussed it with them. Their comments have been incorporated where appropriate. In addition, Pennsylvania Department of Public Welfare and HMA written responses are reprinted in appendix VIII and appendix IX, respectively.

We performed our review between June 1991 and September 1992 in accordance with generally accepted government auditing standards. We reviewed only HealthPASS's prenatal care and EPSDT health care services, HMA's efforts to refer eligible members to WIC, and HMA's physician incentive and quality assurance programs. Therefore, our findings cannot be generalized to include the entire HealthPASS program.

<sup>19</sup>The data bank was established by title IV of the Health Care Quality Improvement Act of 1986. It is a nationwide system, administered by the Department of Health and Human Services, that contains adverse actions taken against a practitioner's license, clinical privileges, or professional society memberships and medical malpractice payments made on their behalf.

# Obstetrical Care Meets ACOG Guidelines When Women Visit Their Obstetrician, but Pediatric Care Needs Improvement

The medical services provided to pregnant women when they visit HealthPASS obstetrical providers meet obstetrical guidelines established by ACOG. But preventive care furnished to children is not meeting professional and federally mandated guidelines. As a result, many children under HealthPASS are not being immunized, screened for lead poisoning and sickle cell anemia, or tested for hearing or vision impairments. Further, many pregnant women and the parents and guardians of children fail to use available services at the recommended intervals. These actions and other risk factors, such as smoking, alcohol, and drug abuse, contribute to complications and poor birth outcomes among pregnant women. In addition, failure to seek and receive adequate preventive care may lead to an increase in the incidence of disease and disability among children. Healthcare Management Alternatives, Inc. has designed educational programs to (1) instruct members about basic health care, (2) inform members about the importance of timely and regular visits to providers, and (3) advise providers about standards for furnishing preventive care to children. Programs targeted towards providers have increased slightly the number of children screened for hearing and vision impairments. But member education and outreach programs do not appear to have significantly increased the numbers of members seeking pregnancy-related care; some EPSDT services, such as lead poisoning screening; or enrollment in the Special Supplemental Food Program for Women, Infants, and Children.

## HealthPASS Providers Follow ACOG Guidelines but Many Patients Do Not Seek Timely Pregnancy-Related Care

Pregnancy-related care provided by HealthPASS to women when they seek such care generally meets obstetrical medical guidelines established by ACOG.<sup>1</sup> Based on our HealthPASS sample, we estimate that for almost 99 percent of the women, providers wrote detailed progress notes that indicated that physical assessments were performed at each prenatal visit, timely and appropriate tests were ordered, and proper treatment was instituted when necessary. Further, our consultant stated that the providers' notations in medical records reflected a constant awareness of the high-risk factors, such as teenage pregnancy, smoking, and sexually transmitted diseases, that are found in this population and could lead to poor birth outcomes. We estimate that over 40 percent of the women in HealthPASS were either teenagers or age 35 and older. Also, over one-third had a previous medical history that included (1) premature births, (2) more than 4 previous births, and sexually transmitted diseases. In

<sup>1</sup>ACOG guidelines refer to both necessary medical services and the timing and frequency of obstetrical visits. Medical services are dependent upon provider skill and knowledge. The timing and frequency of visits is heavily dependent upon patient compliance. We reviewed both aspects.

addition, almost 40 percent used tobacco and alcohol and some admitted to using illicit drugs.

But many women under HealthPASS either did not seek prenatal care during their first trimester or did not return for periodic follow-up visits as ACOG recommends. According to ACOG, women should begin a comprehensive prenatal program as early as possible in the first trimester of pregnancy. The frequency of visits should be determined by a woman's individual needs and risk factors. Generally, a woman with an uncomplicated pregnancy should be seen every 4 weeks during the first 28 weeks of pregnancy, every 2 to 3 weeks until 36 weeks of gestation, and weekly thereafter—a total of approximately 12 visits. Women with active medical or obstetrical problems should be seen more frequently, with the exact intervals to be dependent upon the nature and severity of the problems. After delivery, ACOG recommends a postpartum review and examination within 4 to 8 weeks to determine whether the woman's physiological condition has returned to normal.

Using ACOG guidelines, the Institute of Medicine developed a methodology that classifies pregnancy-related care based on a patient's adherence to early and frequent prenatal care—not on the appropriateness of care furnished by the provider. This methodology correlates the number of prenatal visits, duration of pregnancy, gestational age of the baby at the time of the first visit, and whether care was furnished by the patient's private physician or resident hospital staff.<sup>2</sup> For example, the prenatal care obtained by a woman with a 36-week or longer pregnancy<sup>3</sup> would be classified as:

- adequate, if care began in the first trimester and included nine or more visits;
- intermediate, if care began in the second trimester or included five to eight visits; and
- inadequate, if the care began in the third trimester or included four or fewer visits.

Using the Institute of Medicine's Prenatal Care Index criteria, we estimate that only 25 percent of the HealthPASS women received adequate care.

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<sup>2</sup>In determining the adequacy of prenatal care, we used only the factors relating to the number of visits in relation to the duration of the pregnancy and gestational age at the time of the first visit. We did not use the third factor, type of hospital/physician delivery service, to further classify adequacy. This factor is usually omitted by other researchers who use this prenatal care index.

<sup>3</sup>Appendix I provides details on the Institute of Medicine's Prenatal Care Index classification for women whose babies were born at various gestational ages.



Further, we estimated that over 47 percent received intermediate care and about 28 percent received inadequate care. The lack of motivation, transportation, child care, and an understanding of the importance of pregnancy care are among the reasons HMA believes pregnant women do not seek such care. Additionally, only about 46 percent of the women returned to their health care provider for a postpartum examination.

## **HMA's Attempts to Increase the Number of Obstetrical Visits Have Been Unsuccessful**

A key feature in HMA's contract with the state is that HMA is expected to develop outreach programs focusing on leading causes of death in minority populations, maternal and infant health care initiatives, information and counseling for unwed teenage mothers, and teenage preventive care services. HMA also is expected to assure that care provided to members is appropriate. HMA has developed several outreach and education programs to encourage women to visit an obstetrician as early in their pregnancy as possible. These programs meet the state's contractual requirements; however, these efforts have not significantly increased the number of women seeking early prenatal care. In fact, using the Prenatal Care Index, the number of HealthPASS members who received adequate, intermediate, and inadequate care is similar to that received by Medicaid fee-for-service recipients who have access to very few programs.

Strategies used by HMA to encourage early obstetrical care include (1) distributing brochures and newsletters in the community, (2) scheduling obstetrical visits for pregnant women through county assistant office workers or HMA's telephone hotline operators, and (3) arranging for pregnant women to receive home visits by trained community volunteers under the supervision of nurses. However, HMA officials believe that its programs can be more effective. In 1992, HMA initiated plans to improve the coordination of its pregnancy-related care programs and its data collection activities on the utilization of these programs. To begin this process, in late 1991, HMA also developed a perinatal task force consisting of physicians and other health care professionals to provide coordination of its multiple pregnancy-related programs. The task force meets on an on-going basis to explore ways of improving perinatal care outcomes. For example, one project will include postpartum home visits for new mothers that focus on educating the mother about preventive care for herself and her baby.

Our review of medical records for pregnant Medicaid fee-for-service patients shows results similar to those found in our HealthPASS sample. Specifically, our estimates show that almost 99 percent of the patients received care according to ACOG medical guidelines. But when applying the

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Institute of Medicine's Prenatal Care Index criteria, we found that many women under Medicaid fee-for-service, like women under HealthPASS, either did not go for care during the first trimester or did not make the recommended number of visits. We estimate that for women under Medicaid fee-for-service, about 31 percent received adequate care, about 40 percent received intermediate care, and about 29 percent received inadequate care.

Women under HealthPASS and Medicaid fee-for-service have similar high rates of low birth weight babies, very low birth weight babies, premature babies, and stillbirths, regardless of whether they received adequate, intermediate, or inadequate care. (See table 2.1.) Medical risk factors and life-style choices of the two groups differed only slightly. (See app. II.) In addition to poor birth outcomes associated with infrequent or untimely care, poor outcomes are caused by these other medical risk factors or life-style choices. Further, similar to women under HealthPASS, only 51 percent of the women under Medicaid fee-for-service returned for a postpartum visit.

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**Table 2.1: Pregnancy Outcomes for Women Under HealthPASS and Medical Fee-for-Service Using the Institutes of Medicine Prenatal Care Index<sup>a</sup>**

Pregnancy Outcome <sup>b</sup>	HealthPASS			Medicaid Fee-for-Service		
	Adequate care (N=85)	Intermediate care (N=161)	Inadequate care (N=93)	Adequate care (N=604)	Intermediate care (N=773)	Inadequate care (N=555)
	Number	Number	Number	Number	Number	Number
Normal	59	135	72	531	555	314
Low Birth Weight (1,500 to 2,499 grams)	21	17	8	24	193	48
Very Low Birth Weight (<1,500 grams)	4	0	13	48	0	48
Unknown Birth Weight	0	8	8	0	72	145
Premature Birth (<37 weeks gestation)	13	25	51	97	217	193
Stillbirth	0	0	4	24	0	24

<sup>a</sup>N is the estimated number of women under HealthPASS or Medicaid fee-for-service who received adequate, intermediate, or inadequate care. The figures in the table are the estimated births to women in the categories of care indicated. For example, 59 of the babies born to the 85 (estimated) HealthPASS women who had adequate care were of a normal birth weight. Sampling errors are found in appendix III.

We performed statistical significance tests for the differences found between the two groups of women and found no statistically significant differences between them. Tests were made at the 95 percent confidence level.

<sup>b</sup>Columns do not add up to the N value due to rounding and because premature births and stillbirths are included in the birthweight pregnancy outcomes. Also, both samples had two sets of twins.

Our findings are similar to those of researchers who studied prenatal care and birth outcomes in 1988 at a hospital serving Medicaid women in both HealthPASS and the traditional Medicaid fee-for-service system.<sup>4</sup> These researchers examined 217 deliveries in each group and found no significant difference in pregnancy outcomes. Both groups experienced low rates of adequate prenatal care (39 percent) and high rates of low birth weight (20 percent).

<sup>4</sup>Goldfarb, Neil, et al., "Impact of a Mandatory Medicaid Case Management Program on Prenatal Care and Birth Outcomes," *Medical Care* (1991), Vol. 29, pp. 64-71.

## Many Children Are Not Receiving Required EPSDT Services

HealthPASS children may be susceptible to high-risk illnesses or irreversible or costly disabilities because they are not getting federally mandated EPSDT services. Specifically, title XIX of the Social Security Act requires states to provide preventive health services for Medicaid-eligible children under age 21. These services are to include, among other items, physical exams; immunizations; laboratory tests, such as blood lead levels and sickle cell screening; vision, dental, and hearing services; and necessary follow-up treatment. Title XIX permits each state to select the specific intervals and screening schedule for provision of these services. Pennsylvania requires that EPSDT screening services be provided as recommended by the American Academy of Pediatrics and the American Dental Association. (See app. IV.) However, the state's EPSDT contractor<sup>5</sup> shows that the percentage of eligible HealthPASS children screened in 1992 was only 44 percent. In addition, the Joint Commission's ongoing review of medical records, now totaling about 18,000, shows that, among other items, many children under HealthPASS are not being immunized, screened for lead poisoning and sickle cell anemia, or tested for hearing or vision impairments. (See table 2.2.)

**Table 2.2: Joint Commission's EPSDT Findings as of June 1992**

Joint Commission Pediatric Indicator	Percent of records in compliance
Immunizations furnished	62
Vision screening by age 6	48
Hearing screening by age 6	44
Growth chart present	40
Lead poisoning screening	22
Sickle cell test	18

The Joint Commission cautioned that these deficiencies might be due to a lack of documentation rather than a lack of appropriate care. The Joint Commission, however, did recommend that HMA concentrate its efforts on improving lead poison and sickle cell screening. It should be noted that although the Joint Commission found only 18 percent of medical records contained documentation of sickle cell testing, Pennsylvania, since May 28, 1990, has required such testing for newborns before they are discharged from the hospital. This may account for the low percent of sickle cell testing found by the Joint Commission. But physicians should be determining whether a child has received such testing and documenting such actions in the medical record.

<sup>5</sup>The state contracts with Automated Health Systems, Inc., to provide education and outreach services to all Medicaid-eligible children.

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HMA's own medical record audits have reinforced Joint Commission findings. Specifically, during audits in 1990, HMA found that almost all primary care physicians failed to comply fully with pediatric preventive care guidelines issued by the U.S. Preventive Services Task Force.<sup>6</sup> Although some of the deficiencies noted may be the result of poor documentation, HMA believes some physicians are not providing adequate preventive care. An HMA study performed in 1991 of over 290 children with no record of immunizations showed that only 36 percent of children under HealthPASS were fully immunized, 49 percent were partially immunized, and 12 percent were not immunized at all. The immunization status of the remaining 3 percent was unknown.

In response to the Joint Commission's recommendations and HMA's own findings, HMA made lead screening and sickle cell testing priorities in 1992. In May 1992, HMA sent letters to all primary care physicians discussing the importance of both of these tests. The letters included information on the consequences of lead poisoning, the cost-effectiveness of screening, and the importance of documenting the results of mandatory sickle cell screening. In addition, in June 1992, HMA held a preventive care conference with primary care physicians where the urgency of appropriate lead poisoning and sickle cell screening was reemphasized. Also, in an effort to reduce the incidence of infant lead poisoning, HMA is currently investigating actions to eliminate lead paint risks in the homes of HealthPASS members. It is too early to evaluate the results of these efforts.

The number of children receiving EPSDT services is unknown because not all providers file EPSDT claims.<sup>7</sup> As part of our evaluation of HealthPASS, we interviewed providers who told us that they viewed completing EPSDT claim forms as an administrative burden and, therefore, did not submit them as requested. However, the number of EPSDT claims paid for HealthPASS members generally has increased since HMA took over the program (see figure 2.1).

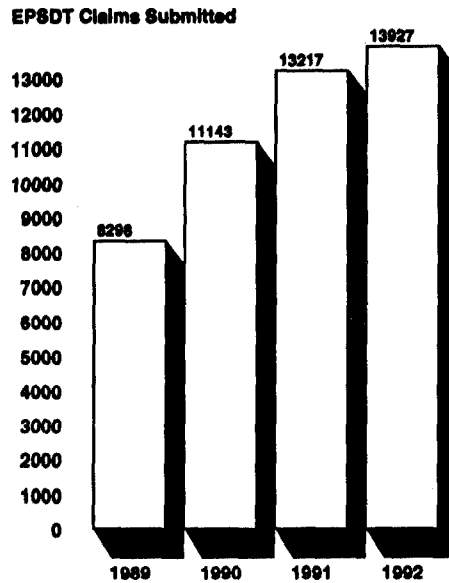
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<sup>6</sup>The guidelines, developed for the Department of Health and Human Services, offer recommendations that primary care physicians should provide their patients in the course of routine care to prevent different illnesses and conditions. The recommendations are grouped by age, sex, and other risk factors.

<sup>7</sup>In order to receive reimbursement for EPSDT services beyond their rate for primary care services, the state requires providers to complete a claim form that serves as a combination invoice, health record, and case-tracking document.

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**Figure 2.1: HealthPASS EPSDT Claims Submitted From July 1989 Through June 1992**



Note: Data for 1989 is based on claims submitted from July 1989 through December 1989 and has been annualized.

HMA is providing in-office training for physicians and their staff about the EPSDT program, including the specific times and intervals within which services must be provided. Also, beginning in April 1991, HMA began sending staff to new providers' offices to conduct EPSDT orientation sessions. To further encourage physicians to provide and document EPSDT services they deliver, HMA raised physician reimbursement for EPSDT screens.<sup>8</sup> Before July 1, 1991, HMA paid \$25 to screen children under the age of 18 months and \$33.50 to screen older children. After July 1, 1991, HMA raised the rate to \$35 for all children. Effective February 1, 1992, Pennsylvania raised the state reimbursement for an EPSDT screen to \$65 for all children under 21.<sup>9</sup> According to a state official, one reason for this action was the state's dissatisfaction with the level of EPSDT screens being reported.

<sup>8</sup>This payment is in addition to the monthly capitation amount HMA pays each physician for primary care services.

<sup>9</sup>HMA also was required to raise its rate to \$65 for an EPSDT screen.

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The Joint Commission's ongoing medical records reviews also indicate an increase in some EPSDT services. The Commission reviewed 3,283 medical records at 24 primary care sites during April, May, and June 1992 that were previously visited in 1990. The Commission found significant increases in vision and hearing screening, a decrease in growth charting, and relatively minor changes in other tests. (See table 2.3.)

**Table 2.3: Joint Commission Medical Record Audit Findings Comparing Results From the Same Provider Sites for 1990 and 1992**

Test	Percent compliance	
	1990	1992
Vision screening	54.00	81.92
Hearing screening	52.12	61.92
Immunizations	73.71	75.94
Sickle cell testing	36.82	36.06
Lead screening	37.94	38.05
Growth chart	56.59	49.50

**Parents or Guardians Need to Take More Responsibility for Keeping Medical Appointments**

HMA and providers are not solely responsible for ensuring that children receive required preventive services. Parents or guardians also play an important role. But many HealthPASS children do not receive care because their parents or guardians do not keep scheduled health care appointments. From July 1989 through June 1991, only 50.3 percent of 17,255 HealthPASS appointments reviewed by the state's EPSDT contractor were kept. This rate is similar for 54,397 Medicaid fee-for-service EPSDT appointments made statewide during the same period. Only 53.8 percent of these children appeared for their appointments. To understand why members make appointments and then do not keep them, HMA asked a sample of 293 HealthPASS members during its immunization study what problems they had with accessing care. The majority reported no problems. Others cited lack of transportation and lack of child care and appointment scheduling and financial problems.

Community advocates we interviewed stated that poor social and economic conditions are contributing factors to not keeping health care appointments. One advocate stated that a low-income person's first priority usually is obtaining cash assistance; preventive health care often is a low priority. Also, the cost of transportation, accessing it, and obtaining child care for other children when taking a child to an appointment can be burdensome. For example, because a provider may not allow more than two children in a family to be seen at any one time, a parent with more

than two children might have to schedule several EPSDT appointments for different days.

HMA is trying to educate parents and guardians about the importance of EPSDT services. Since 1990, HMA has mailed immunization schedules and reminder letters to parents, given mothers T-shirts for their newborns with the immunization schedule imprinted on the shirt, arranged for prenatal and postpartum home visits, and emphasized childhood immunizations during the HealthPASS enrollment process. HMA also has published in its member newsletter articles on immunizations, lead screening, and sickle cell testing. In addition, while making home visits during its immunization study, HMA emphasized the importance of the EPSDT program with parents and gave them brochures explaining the program. In May 1991, HMA helped sponsor a city-wide immunization program. Almost 6,000 children were immunized during this campaign, of which about 350 children were HealthPASS members. HMA also is working to break down barriers to care. Its staff is helping members schedule EPSDT appointments and make arrangements for free transportation available through the Medical Assistance Transportation Program.<sup>10</sup> No current data are available to determine the success of these efforts.

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## **HMA Informs Members About WIC but Could Take Other Measures to Improve Enrollment**

HMA's efforts to encourage members to join the WIC program can be improved. But HMA is not obligated by its contract to refer or enroll its members in the WIC program. The WIC program, established in 1972 through an amendment to the 1966 Child Nutrition Act, was developed to improve the health of low-income pregnant, breastfeeding, and postpartum women and their children (up to age 5) who are at nutritional risk. WIC provides supplemental foods, nutrition and health education, and health services referral.<sup>11</sup>

In our sample of pregnant women, we found the percentage of eligible women in HealthPASS enrolled in the WIC program to be approximately the same as women in the traditional Medicaid fee-for-service system—74 percent and 69 percent, respectively. Similarly, mothers in HealthPASS enrolled 72 percent of their children born during the study period

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<sup>10</sup>In Philadelphia, the Medical Assistance Transportation Program provides nonemergency medical transportation for eligible persons to and from medical providers enrolled in Medicaid. It provides reimbursements to cover the fare for public transit trips or the costs for privately owned vehicles. The program also provides paratransit service for persons who do not have a car or are physically or emotionally unable to use public transportation.

<sup>11</sup>The Pennsylvania Department of Health oversees the WIC program.



as compared with mothers in the Medicaid fee-for-service system who enrolled 74 percent of their children.

Despite having no contractual requirement to enroll its members in WIC, HMA has been working to educate HealthPASS members about the WIC program through a variety of means. For example, HMA representatives call all new HealthPASS members through HMA's Tele-reach program to explain program eligibility and benefits and to provide them with the WIC program office locations and telephone numbers. Similarly, if members call HMA's telephone hotline for any reason and they are assessed to be eligible for WIC, representatives provide members with WIC information. Pregnant teenagers and teenage parents are encouraged to enroll in WIC through HMA's Pregnant Teen and Parenting Teen groups. As part of HMA's Lay Home Visiting Program, trained community members are sent into the homes of pregnant women and new mothers to encourage them to enroll in WIC. Likewise, HMA's Unborn/Newborn Initiative encourages pregnant women and new mothers to enroll in WIC.

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### **More Can Be Done to Increase WIC Enrollment**

Enrollment of HealthPASS members in the WIC program could increase substantially if HMA provided the names of its members to the WIC program. Currently, this exchange is not occurring. EPSDT claim forms show whether a child being screened is enrolled in the WIC program. These data are maintained by the state's EPSDT contractor and would be helpful if used to target eligible children for WIC enrollment. In January 1992, we suggested to state officials that HMA share these data with the WIC program. The state agreed. Later, in May 1992, HMA similarly suggested that it provide to WIC the names and other pertinent information of all new HealthPASS members who are pregnant and the names of children under age 5 in the program. HMA, however, was concerned about maintaining member confidentiality. The state discussed the issue and HMA's concerns with HCFA. HCFA officials rejected the idea. In a February 23, 1993, meeting with HCFA regional office personnel, we were told that HCFA officials took this action because they thought that the state was requesting to release names of HealthPASS members to WIC providers, a prohibited practice. HCFA did, however, agree that the state agencies responsible for administering the state Medicaid and WIC programs can devise an information exchange with proper safeguards where recipient confidentiality will be preserved. Under 42 U.S.C. 1396a(a)(11), state Medicaid plans are required to provide for coordination of operations with state WIC programs.

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## **Physicians and Community Representatives Prefer HealthPASS Over Fee-for-Service**

The HealthPASS primary care physicians we spoke with generally indicated that HealthPASS was better than the traditional Medicaid fee-for-service system at providing access to primary and specialty care, educating patients and physicians, and making financial reimbursements. The community group representatives we spoke with also generally felt that HealthPASS was better than the traditional Medicaid fee-for-service system in areas such as pediatrics, preventive care, outreach, and recipient costs. For example, one welfare rights advocate cited as an advantage HealthPASS's lack of required copayments and the ability of advocates to call HMA directly to resolve problems. Another community group representative, citing HMA's funding of a middle school clinic, commended HealthPASS for improving access to care. However, some representatives we spoke with believe that HealthPASS has not increased access to health care.

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## **Conclusions**

HMA's efforts to increase the number of members seeking and keeping appointments for pregnancy-related care and EPSDT services are meeting with limited success. But changing the behavior of Medicaid recipients is a very difficult problem. HMA officials recognize that the need to improve their efforts and they are taking actions to do so. We encourage them to continue with these efforts, monitor their success, and alter them as necessary until the desired outcome is reached.

Regarding HMA's efforts to enroll HealthPASS members in the WIC program, information on women and children who are eligible for WIC is available and can and should be shared with WIC.

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## **Recommendations**

We recommend that the Secretary of Health and Human Services direct the Administrator of the Health Care Financing Administration to require the Pennsylvania Department of Public Welfare and Department of Health to make the necessary arrangements to allow HMA to provide the names of HealthPASS members to the WIC program.

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## **HMA, State, and HCFA Comments**

In a February 26, 1993, letter, the chief executive officer (CEO) of HMA generally agreed with our findings and recommendations. However, he believes that it may be years before HMA programs make a significant difference because of problems relating to poverty that confront the population. The CEO stated that HMA continually works on improving WIC enrollment and immunizations. He also believes that HMA is performing relatively well in both areas when compared to the Medicaid

fee-for-service program in Philadelphia. To support this contention, he cited 1988 data published in a Pennsylvania Department of Health study stating that only 50 percent of Philadelphia's target population was enrolled in WIC. He further cited city-wide data that indicate that (1) 60 percent of children at all income levels are not fully immunized and (2) 32 percent of Medicaid fee-for-service children received required EPSDT screens in 1992 compared to the 44 percent rate achieved by HMA.

Although the data cited by HMA may be useful, our concern is with how well HMA is performing its mission. Federal law requires all Medicaid-eligible children under 21 years of age to be offered screening services. In our opinion, this is the appropriate criteria against which to measure HealthPASS's EPSDT program. With respect to WIC enrollment, we developed comparative figures for HealthPASS and Medicaid fee-for-service recipients and found no significant difference in the enrollment of the two groups.

The deputy secretary of the Pennsylvania Department of Public Welfare provided written comments on March 2, 1993. The deputy secretary concluded that much needs to be done to improve the use of prenatal care, pregnancy outcomes, and EPSDT screening and followup for children in both the HealthPASS and fee-for-service programs. He also stated that the department and HMA will continue to

- ensure that the HealthPASS program satisfies the original goals of maintaining or improving access to and the quality of medical services provided while reducing health care expenditures,
- evaluate the feasibility of other prenatal and preventive care initiatives,
- focus on special initiatives to address critical preventive health care issues, and
- evaluate the feasibility of sharing patient information with WIC.

The deputy secretary expressed serious concern about our use of Joint Commission data to measure HMA's compliance with EPSDT requirements. In his opinion, the Joint Commission assessed the presence or absence of an event as opposed to an assessment or judgment of the treatment provided or not provided. The deputy secretary also believes that we should have determined the differences between Medicaid fee-for-service and HealthPASS EPSDT services.

We disagree. The Joint Commission is the state's contractor for determining if appropriate health care is being furnished to HealthPASS

members. To perform this task, the Joint Commission reviews medical records to make determinations as to whether specific services, such as administration of immunizations, sickle cell testing, and lead poison screening, have been provided appropriately. The state approved the criteria used by the Joint Commission to make such determinations. We believe the data obtained from such an effort are sufficient to show that improvements are needed in the EPSDT program. Further, HMA's own medical record audits have reinforced Joint Commission findings.

We did not compare compliance rates of HealthPASS and Medicaid fee-for-service providers in the area of EPSDT because the law requires 100-percent compliance with EPSDT standards. In this area, we measured the actual performance of HealthPASS providers, not their performance relative to others.

On February 23, 1993, we met with officials in HCFA's Philadelphia Regional Office to obtain their views on the draft report. These officials told us that names and other identifying information about HealthPASS members cannot be shared directly with WIC providers. However, HCFA agrees that this information can be shared with the WIC state agency by state officials responsible for the HealthPASS program.

# HMA Financial Incentives Are Designed to Adequately Compensate Physicians

Healthcare Management Alternative, Inc.'s financial incentive arrangements with primary care physicians are designed to control medical costs and reduce the likelihood that care provided to members will be limited inappropriately because physicians fear financial loss or seek financial gain.<sup>1</sup> This strategy also enhances HMA's ability to remain competitive with other managed care plans operating in its service area. Although the evidence is inconclusive, financial incentives may have been a factor in determining what services are furnished to patients. We found, for example, that the number of mammogram referrals increased in 1991 when HMA stopped charging primary care physicians for such referrals. In January 1993, HMA took action that should further increase the possibility that appropriate referrals will be made. Under the new arrangements, capitation rates have been increased and, if providers meet certain quality assurance requirements, any deficit balances in their specialty referral accounts at the close of the fiscal year will be forgiven by HMA.

## HMA Has Changed Its Financial Arrangements With Primary Care Physicians

In July 1991, HMA made several changes to its financial incentive package that were designed to increase physician reimbursement while continuing to control unnecessary utilization of medical services. These changes were brought about by physicians' concern that they were being called upon to assume an inordinate amount of the financial risk for caring for HealthPASS members. Specifically, HMA increased its monthly capitation rate and reduced physician liability for specialty referrals.

HMA pays primary care physicians a fixed monthly physician capitation fee for each member enrolled in their practice to cover the cost of their medical services and specialists to whom they make referrals.<sup>2</sup> The monthly payment remains the same no matter how often, if ever, the physician provides services to the member or how much the services cost. HMA increased the monthly amount it pays physicians for primary care services (see table 3.1) because HealthPASS primary care providers, especially those with practices consisting of severely ill patients, voiced concerns about the reimbursement rate being too low to compensate them adequately for furnishing necessary care.

<sup>1</sup>Physician financial incentive programs are designed to limit inappropriate utilization of health care services. HMA's program is described in chapter 1 of this report.

<sup>2</sup>A primary care physician can belong to a group or association of physicians whose medical practice is located at one or more sites, or a single physician can have more than one location where patients are treated. Thus, HMA tracks capitation payments and specialty referral fund balances by primary care physician site.

**Chapter 3**  
**HMA Financial Incentives Are Designed to**  
**Adequately Compensate Physicians**

**Table 3.1: Comparison of Primary Care Physician Capitation Rates Effective Before and on July 1, 1991**

Member age category	Capitation rate	
	Before July 1, 1991	Effective July 1, 1991
00<01	\$14.19	\$19.50
01<02	14.19	17.50
02<04	6.08	7.50
04<14	6.08	7.00
14-43 (male)	5.27	5.27
14-43 (female)	9.81	10.50
44-65	13.22	13.22
Over 65	5.27	5.27

In addition to the changes in primary care capitation rates, HMA assumed greater financial responsibility for the costs of specialists' care recommended by primary care physicians. Specifically, HMA lowered from \$4,000 to \$1,000 per patient the maximum amount that a primary care physician is at risk of repaying for specialist referrals.<sup>3</sup> As a result of this change, a significant shift occurred in the financial liability of primary care physicians for referral services. Specifically, on December 31, 1990, physicians owed HMA \$3,018,262; on December 31, 1991, physicians owed HMA \$366,725—a decrease in financial liability of over \$2.6 million.<sup>4</sup> Further, we found that the number of primary care physician sites that had positive balances in their referral service fund and received bonuses increased,<sup>5</sup> the number that had negative balances and incurred deficits decreased, and the number that left the HealthPASS program decreased.<sup>6</sup> (See table 3.2.)

<sup>3</sup>This change did not limit the primary care physicians' ability to refer to a specialist.

<sup>4</sup>These end-of-the-year referral services fund balances are not cumulative from one year to the next. These figures reflect the net amount physicians owed HMA at the end of each given year.

<sup>5</sup>Without further study, no inference can be made about the relationship between bonuses and the number of referrals made to specialists. Increased bonuses can be the result of either low physician liability for specialty referrals or the result of few referrals. HMA's quality assurance program, which monitors the frequency and appropriateness of specialty referrals, should help to mitigate untoward effects on the provision of health care.

<sup>6</sup>If a physician chooses to leave the program, any deficit balance in the specialty referral fund is forgiven.

**Chapter 3  
HMA Financial Incentives Are Designed to  
Adequately Compensate Physicians**

**Table 3.2: Bonuses Received, Deficits Incurred, and Amounts Forgiven by HMA**

	1990		1991	
	Number of sites	Amount	Number of sites	Amount
Bonuses	81	\$ 116,307	111	\$ 936,812
Deficits	144	3,134,569	94	1,303,537
Left the program	21	99,706	15	107,806

HMA made two other changes designed to encourage primary care physicians to provide appropriate medical services without incurring financial loss. First, the primary care physician's referral services fund was no longer assessed if a pregnant woman was referred to either an obstetrician during her first trimester or to the Healthy Beginnings Plus<sup>7</sup> program anytime during her pregnancy. Second, the primary care physician's fund is no longer charged for a mammogram referral.

Assessments made by HMA 6 months after the change in reimbursement for mammograms showed a general increase in the percentage of women who received mammograms. (See table 3.3.) HMA attributes the increase to several factors, including changing the mammogram reimbursement incentive, distributing the U.S. Preventive Care Task Force Guidelines to primary care physicians, and holding a conference for primary care physicians on cancer screening.

**Table 3.3: Comparison of Percentage of Women Who Received Mammograms Before and After HMA Changed the Financial Incentive**

Age category	Percent of women receiving mammograms	
	6 months before	6 months after
45 to 49	10.9	13.8
50 to 64	12.7	15.1
65 to 70	5.9	8.3

In June 1992, HMA initiated a quality assurance procedure that identified providers who may be underserving HealthPASS members because they are unduly influenced by financial incentives. Specifically, HMA revised its recredentialing process for primary care physicians in order to better identify problem physicians. HMA now develops individual profiles for every primary care physician in the program. These profiles include information such as results of medical records audits, a summary of services provided to patients, and any information about HealthPASS

<sup>7</sup>A maternity benefits program funded by the state and federal governments that emphasizes comprehensive and coordinated services.

member satisfaction with that provider. In September 1992, while recredentialing primary care physicians, HMA's quality assurance staff began analyzing these profiles to identify patterns or trends that might warrant corrective action. The evaluation identified 27 physicians for further review because their patient encounters, referrals to specialists, hospitalizations, emergency room referrals, and pharmacy use were 40 percent above or below the plan average. At least 8 of these physicians underutilize some services. HMA is currently examining the circumstances surrounding each of these cases and plans follow-up actions as appropriate.

## HMA Revised Its Financial Incentive Program in Response to Continued Physician Concern

HMA made additional changes to its financial incentive arrangements with primary care physicians in January 1993. Despite the July 1991 changes to its financial incentive arrangements, HMA continued to receive complaints from primary care physicians that they were not being compensated adequately for their services. Further, HMA was the only managed care plan in the area that used a specialty referral fund as a physician incentive to contain health care costs. HMA believed that its policies made them uncompetitive with other managed care plans in the area and caused physicians to openly encourage HealthPASS members to join alternate plans. In response, HMA increased capitation rates again and modified provisions governing payback of deficits in the specialty referral fund.

Primary care capitation rates for children from birth to age 1 were increased by \$10.50 per child per month, from \$19.50 to \$30.00. Additionally, for children age 2 to 4, the rate increased \$6.50 per child per month, from \$7.50 to \$14.00. The amount set aside from the physician capitation rate for the referral services fund also increased by \$1.00 per member per month retroactive to February 1992 and \$.20 per member per month effective January 1, 1993. (See table 3.4.)



**Chapter 3  
HMA Financial Incentives Are Designed to  
Adequately Compensate Physicians**

**Table 3.4: Total Referral Services Fund  
Capitation Rates Effective January 1,  
1993**

<b>Member Age Category</b>	<b>Referral services fund capitation rate</b>
00<01	\$6.06
01<02	6.06
02<04	4.43
04<14	4.43
14-43 (male)	9.62
14-43 (female)	15.61
44-65	12.83
Over 65	6.43

Several other financial changes linked to quality assurance and utilization review requirements could result in the elimination of current and future deficit balances in physician referral specialty funds. The first change, effective January 1, 1993, defers payback of fund deficits until at least the end of the year if physicians at the site agree to accept all HealthPASS members seeking care during the year.<sup>8</sup> Until the end of the year, however, charges to the referral specialty fund will continue to accrue. The second change will eliminate any accumulated deficit balance in the referral fund if the provider site accepted all HealthPASS members requesting care during the full 12 months of 1993 and the site met the following requirements:

- submitted all requested documentation needed for credentialing and recredentialing;
- experienced no major unresolved quality-of-care problems as identified by the Provider Affairs Subcommittee using the primary care physician profile described on page 39 of this chapter;
- achieved at least an 80 percent encounter form submission rate, increased encounter filing by at least 20 percent over the year, or both;
- cooperated with HMA's request to conduct a member satisfaction survey at least once during the year; and
- demonstrated the ordering of appropriate referrals as determined by a methodology to be developed with input from the Quality Assurance Committee and the Provider Affairs Subcommittee.

Other changes to the physician compensation program include: (1) paying primary care physicians the Medicaid fee-for-service rate plus 10 percent when they are the attending physician for hospitalized patients in their practice and (2) increasing significantly the amount set aside in the hospital management fund.

<sup>8</sup>Some providers have limits on the number of HealthPASS members they will admit to their practice.

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**Conclusions**

With each change to the financial incentive program, HMA has assumed greater financial responsibility for referrals to specialists and moved to lessen the likelihood that physicians will limit their specialist referrals inappropriately. These changes also have served to (1) address primary care physicians' concerns that they are not being compensated adequately and (2) enhance HMA's capability to remain competitive with other managed care plans operating in their service area. Whether the latest changes made in January 1993 will increase access to and quality of services is not yet determinable.

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**HMA, State, and  
HCFA Comments**

Technical changes suggested for this chapter have been included.

# HMA's Quality Assurance Program Meets Standards but Physician Credentialing Could Be Improved

HMA has a quality assurance program that meets both federal and state requirements. The program is considered comprehensive by experts who evaluated it for Pennsylvania's Department of Public Welfare and provides HMA management with the information necessary to focus on pertinent quality-of-care issues. However, HMA's physician credentialing procedures need to be improved. Currently, HMA is unaware that it contracts with at least 3 physicians who have been sanctioned by either a hospital or the Pennsylvania State Board of Osteopathic Medicine and 72 physicians who have had malpractice judgments against them. HMA has access to, but makes no attempt to obtain, licensure information from the Federation of State Medical Boards—a private organization that compiles data about physicians who have had state board sanctions taken against their license—when it contracts with a physician. Conversely, it cannot obtain information from the National Practitioner Data Bank because HMA, by statute, does not have access to this system.

## HMA's Quality Assurance Program Meets Standards and Identifies Quality of Care Problems

The U.S. Department of Health and Human Services regulations, 42 C.F.R. 434.34, and HMA's contract with Pennsylvania require HMA to have a program that includes quality assurance and utilization review measures to assure that members receive quality care. (See app. VI.) Additionally, because HMA is a health insuring organization, the state requires it to have certain quality assurance mechanisms that are not mandated under the traditional Medicaid fee-for-service system. These mechanisms include: (1) establishing a medical director and advisory committees to oversee the quality of care provided, (2) implementing a peer review program, (3) assuring access to specialist care, and (4) adhering to the Joint Commission's 10-step process for monitoring and evaluating the quality of care provided. (See app. VII.) Although the Department of Public Welfare reviews and approves HMA's quality assurance program, state officials contract with the Joint Commission to assess the program's appropriateness and effectiveness.

Our comparison of HMA's quality assurance program to federal regulations governing a health insuring organization showed that HMA's program met requirements.<sup>1</sup> An HCFA official responsible for monitoring HealthPASS agreed with our assessment. In addition, HMA's quality assurance program meets state contract requirements. In fact, we found that the program exceeded

<sup>1</sup>In a previous report, we found that (1) HealthPASS's quality assurance program was only partially implemented, (2) reviews were not focused on quality of care, and (3) an HCFA-required external peer review program had not been implemented. Since that report, these deficiencies have been resolved. See Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program (GAO/HRD-88-37, Dec. 22, 1987), pp. 10-11.

the guidelines set forth by the state for traditional Medicaid fee-for-service providers.

Pennsylvania's Department of Public Welfare contracted with the Joint Commission in May 1989 to monitor and evaluate the effectiveness of HMA's quality assurance program. In March 1990, the Joint Commission began its review. Two years later, in March 1992, the Joint Commission told Pennsylvania Department of Public Welfare officials that HMA has developed a quality assurance program that exceeds traditional Medicaid quality assurance practices.<sup>2</sup> The Joint Commission believes that HMA has successfully incorporated problem-solving methods in its quality assurance program making it state-of-the-art. In addition, another consultant<sup>3</sup> found HMA has effective policies, procedures, control methods, and practices that are ensuring quality care for HealthPASS members. This consultant concluded that both the process and outcome measures used in HMA's quality assurance program are superior to those found in the traditional Medicaid fee-for-service programs.

As part of its quality assurance program, HMA staff identify potential quality-of-care problems, implement actions to correct them, and evaluate the effectiveness of these actions. Many of these activities detect situations where needed care is not being provided. For example, in early 1991, HMA quality assurance staff reviewed claims data and identified low utilization of mammography to detect breast cancer. As mentioned in chapter 3, in July 1991 HMA provided physicians with a financial incentive to refer their patients for mammograms by no longer charging physicians for mammography referrals. Although the results of this effort were positive (see table 3.3), HMA decided more needed to be done. Thus, in July 1992, HMA began designing an initiative to further increase mammogram utilization. In November 1992, female members age 50 and over who had not received a mammogram within the last year began receiving mammogram reminder letters, educational materials, and incentives designed to encourage them to request their primary care physician to schedule a mammogram. The effectiveness of the project will be evaluated by comparing mammography utilization 6 months before and

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<sup>2</sup>HMA appointed a medical director in December 1990 who led the response to the Joint Commission's initial concerns and brought the quality assurance program to its current high level of acceptance by the Joint Commission. In August 1992, the medical director left the HealthPASS program. The associate medical director was promoted to the position of medical director.

<sup>3</sup>SOLON Consulting Group, Ltd., was hired in April 1991 by the Pennsylvania Department of Welfare to assess access to care, quality of care, cost effectiveness, and the effectiveness of the case management function. SOLON's evaluation was for the period July 1, 1989, through December 30, 1990.

6 months after the start of the project. HMA plans to report on the results of this initiative in July 1993.

## **HMA's Physician Credentialing Program Can Be Improved**

HMA's physician credentialing program does not identify all physicians who have had sanctions taken against them or their licenses or malpractice claims paid on their behalf.<sup>4</sup> This occurs even though HMA requires a provider applying to the program to respond to specific questions pertaining to these matters. HMA could utilize the services of national information systems that contain such data—but does not. As a result, HMA is unknowingly contracting with physicians whose previous performance was substandard or whose conduct was unprofessional.

HMA must contract with all physicians who want to participate in HealthPASS if they hold a valid Pennsylvania Medical Assistance agreement and are licensed to practice in Pennsylvania. Additionally, the physician must hold current Drug Enforcement Authority certification, professional liability insurance, attestations confirming continuing medical education and hospital admitting privileges, and approvals from certain HealthPASS physician committees. However, HMA does not have to continue the contract if HMA, through its ongoing evaluation of the physician's practice, discovers that member care is being compromised. This evaluation is based on medical records reviews, results of member satisfaction surveys, and evaluations of utilization information relating to each physician.

The Federation of State Medical Boards maintains files, which go back to the 1960s, that contain the names of physicians who have had adverse actions taken against their license. This information is reported to the Federation by individual state medical boards and other authorities and is very similar to that contained in the National Practitioner Data Bank. For a negotiated fee per inquiry, the Federation provides this information to organizations, such as hospitals or HMOS, who require information for credentialing purposes. However, HMA does not have a contract with the Federation.

The National Practitioner Data Bank contains adverse actions taken against practitioners and any medical malpractice payments paid on their behalf. Adverse actions are provided to the Data Bank by state licensing boards, hospitals, professional societies, and health care entities that provide direct health care services and engage in professional review

<sup>4</sup>In addition to a state instituting sanctions against a physician's license, a hospital might institute sanctions, such as restricting a physician's privileges or requiring supervision, when the physician undertakes certain procedures.

activity through a formal peer review process. Malpractice payments are reported by any entity, such as an insurance company, that makes a payment in settlement of a written claim or judgment against a provider. Hospitals, licensing boards, certain health care entities that provide health care services and have a formal peer review process, attorneys, physicians, dentists, and other health care practitioners can access the Data Bank. Because HMA is a health insuring organization that does not provide direct health care services, it does not have access to National Practitioner Data Bank information.

To determine if any HealthPASS physicians had been reported to the National Practitioner Data Bank, we matched the names of participating HealthPASS physicians with information in the National Practitioner Data Bank. We found that 72 of the approximately 2,200 HealthPASS providers had malpractice claims totaling at least \$40 million paid on their behalf.<sup>5</sup> More importantly, 3 physicians had sanctions taken against their licenses: one had his license suspended because of hospital concerns about his obstetrical care, another resigned his practice after issues were raised by a hospital about the quality of his care, and the third was placed on probation by the Pennsylvania State Board of Osteopathic Medicine after being suspended from practice for 4 weeks. Details of the latter case were unavailable to us.<sup>6</sup>

To determine whether data on sanctioned physicians are available from the Federation of State Medical Boards, we provided the names of the three aforementioned physicians to it for a credentials check. The name of the physician who had a sanction against his license was in their files. The other two physicians' names were not because their adverse actions did not involve licensing sanctions.

## Conclusions

HMA would benefit by contracting with the Federation of State Medical Boards to identify potential problem physicians before they contract with the HealthPASS program. Being aware of potential problem physicians would allow HMA to efficiently monitor and evaluate those providers' practice patterns. HMA would also benefit if it had access to the National

<sup>5</sup>Payment of a malpractice claim on a physician's behalf is not a definite indication that the provider is negligent or guilty of any wrongdoing. However, malpractice payments indicate that a problem may exist warranting further investigation.

<sup>6</sup>While testing its new physician credentialing profile form, HMA identified this physician as a potential problem due to low hospital and specialist referrals and because his encounters with patients and emergency room usage was low.

Practitioner Data Bank, although gaining access to the Data Bank will require legislative action.

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**Matter for  
Consideration of the  
Congress**

The Congress may wish to consider amending title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660) to require health insuring organizations to participate in the National Practitioner Data Bank. By doing so, health insuring organizations like HealthPASS could access information needed to identify unethical or incompetent practitioners.

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**Recommendation**

We recommend that the Secretary of Health and Human Services direct the Administrator of the Health Care Financing Administration to direct the state to modify its contract with HMA to require HMA to query nationwide information banks to improve the identification of potentially problematic physicians in the HealthPASS program.

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**HCFA, State, and  
HMA Comments**

In its February 26, 1993, letter, HMA agreed with our recommendation that the Congress should consider permitting HMA to access the National Practitioner Data Bank, but also said that accessing the American Federation of State Medical Board's information might be duplicative. Thus, HMA plans to seek access to the National Practitioner Data Bank, but will not seek a contract with the Federation. However, we believe HMA should seek information from the Federation as soon as possible because physician information would be available to it immediately. Later, HMA should obtain information from the National Practitioner Data Bank if the Congress determines it will take action to expand access. Further, we believe access to both data files is needed because the scope of the two differ. We recognize that both data banks contain similar information, however, they differ in several important ways. The National Practitioner Data Bank contains information about malpractice awards that the Federation's files do not contain. Conversely, the Federation files contain sanction information dating back to the 1960s while the Data Bank contains information dating back only to the late 1980s.

Pennsylvania's Department of Public Welfare commented that although information in the respective data banks cannot be used to preclude a provider from participating in the HealthPASS program, the data would be valuable during recredentialing when it can be used in conjunction with other provider performance indicators. We concur. At that time, potential problem physicians can be identified and subsequently monitored.

# Institute of Medicine Prenatal Care Index

The prenatal care index classification for women who gave birth at various gestational ages.

<b>Prenatal care is</b>	<b>Trimester prenatal care began is</b>	<b>Gestational age of baby at delivery in weeks:</b>	<b>Number of prenatal visits:</b>
Adequate	First (within first 13 weeks) and	13 or less	1 or more
		14-17	2 or more
		18-21	3 or more
		22-25	4 or more
		26-29	5 or more
		30-31	6 or more
		32-33	7 or more
		34-35	8 or more
		36 or more	9 or more
		Inadequate	Third (28 weeks or later) or
22-29	1 or less		
30-31	2 or less		
32-33	3 or less		
34 or more	4 or less		
	All combinations other than specified above		
Intermediate			



# Comparison of Risk Factors Between HealthPASS Members and Fee-for-Service Recipients<sup>a</sup>

Risk factor	HealthPASS	Fee-for-service
	(Percent)	(Percent)
Teenager:	28.4 (+/-10.0)	31.2 (+/-11.0)
Age 35 or over	13.5 (+/-7.7)	9.1 (+8.0/-5.0)
Used tobacco	28.9 (+/-9.9)	42.9 (+/-11.7)
Used alcohol	14.5 (+/-7.8)	16.9 (+/-9.0)
Used drugs	7.9 (+7.0/-4.1)	9.1 (+8.0/-5.0)
First pregnancy	17.5 (+/-8.1)	16.9 (+/-9.0)
Sexually transmitted disease	20.0 (+/-8.5)	21.3 (+/-9.6)
Previous premature births	7.5 (+6.6/-4.0)	8.8 (+7.7/-4.8)
More than 4 previous births	18.8 (+/-8.3)	10.0 (+/-7.2)
Asthma condition	10.0 (+/-6.5)	11.3 (+/-7.6)

<sup>a</sup>Sampling errors at the 95-percent confidence level are given in the parenthesis below the estimate.

We performed statistical significance tests for the differences found between the two groups of women. Tests were made at the 95-percent confidence level. Based on our sample results, we conclude that there are no true underlying differences for the measures shown above.

# Sampling Errors: Pregnancy Outcomes for HealthPASS and Fee-for-Service Women Using the Institute of Medicine Prenatal Care Index<sup>a</sup>

Pregnancy	HealthPASS			Medicaid fee-for-service		
	Adequate care N=85 (+/-31)	Intermediate care N=161 (+/-35)	Inadequate care N=93 (+/-32)	Adequate care N=604 (+/-208)	Intermediate care N=773 (+/-220)	Inadequate care N=555 (+/-204)
	Number	Number	Number	Number	Number	Number
Normal birth weight	59 (+/-27)	135 (+/-35)	72 (+/-29)	531 (+/-201)	555 (+/-204)	314 (+/-168)
Low birth weight (1,500 to 2,499 grams)	21 (9 to 43)	17 (6 to 37)	8 (2 to 26)	24 (1 to 128)	193 (+/-139)	48 (7 to 163)
Very low birth weight (<1,500 grams)	4 (1 to 20)	0 (14 or less)	13 (4 to 32)	48 (7 to 163)	0 (87 or less)	48 (7 to 163)
Unknown birth weight	0 (14 or less)	8 (2 to 26)	8 (2 to 26)	0 (87 or less)	72 (17 to 196)	145 (60 to 288)
Premature birth (<37 weeks gestation)	0 (4 to 32)	25 (12 to 48)	51 (+/- 26)	97 (30 to 227)	217 (+/-146)	193 (+/-139)
Stillbirth	0 (14 or less)	0 (14 or less)	4 (1 to 20)	24 (1 to 128)	0 (87 or less)	24 (1 to 128)

<sup>a</sup>N is the estimated number of HealthPASS or Medicaid fee-for-service women who received adequate, intermediate, or inadequate care. The figures in the table are the estimated births to women in the categories of care indicated. For example, 59 of the babies born to the 85 (estimated) HealthPASS women who had adequate care were of a normal birth weight. Sampling errors at the 95-percent confidence level are in the parenthesis below the estimate.

We found no statistically significant differences between the two groups of women. Tests were made at the 95-percent confidence level.

<sup>b</sup>Columns do not add up to the N value due to rounding and because premature births and stillbirths are included in the birthweight pregnancy outcomes. Also, both samples had two sets of twins.

# Pennsylvania's EPSDT Program Periodicity and Screening Schedule

Selected Screen	Month							
	<2	2-3	4-5	6-8	9-11	12-14	15-17	18-23
Health & development history	1	1	1	1	1	1	1	1
Physical exam	1	1	1	1	1	1	1	1
Growth measurements	1	1	1	1	1	1	1	1
Head circumference	1	1	1	1	1	1	1	1
Dental								
Vision	3	3	3	3	3	3	3	3
Hearing	3	3	3	3	3	3	3	3
Developmental assessment	1	1	1	1	1	1	1	1
Tanner score <sup>a</sup>								
Hematocrit or hemoglobin						2	1	2
Tuberculin							1	2
Urinalysis								
Blood lead						1	2	2
Sickle cell	If indicated by history and/or symptoms							
Sexually transmitted disease	If indicated by history and/or symptoms							
Immunizations	See appendix V							

## Key:

1 = Provide at this time.

2 = Provide at this time unless done previously.

3 = Assessed through observation and/or through health history/physical

<sup>a</sup>A measurement of the sexual maturation process that aids in assessing height growth patterns and prognosis.

**Appendix IV  
 Pennsylvania's EPSDT Program Periodicity  
 and Screening Schedule**

Selected screen	Year											
	2	3	4	5	6	8	10	12	14	16	18	20
Health & development history	1	1	1	1	1	1	1	1	1	1	1	1
Physical exam	1	1	1	1	1	1	1	1	1	1	1	1
Growth measurements	1	1	1	1	1	1	1	1	1	1	1	1
Head circumference	1											
Dental	1	1	1	1	1	1	1	1	1	1	1	1
Vision	3	2	2	1	1	1	1	1	1	1	1	1
Hearing	3	2	2	1	1	1	1	1	1	1	1	1
Developmental assessment	1	1	1	1	1	1	1	1	1	1	1	1
Tanner score				1	1	1	1	1	1	1	1	1
Hematocrit or hemoglobin	1	1	1	1	1	1	1	1	1	1	1	1
Tuberculin	1	2	1	2	1	1	1	1	1	1	1	1
Urinalysis	1	1	1	1	1	1	1	1	1	1	1	1
Blood lead	1	1	1	1	1							
Sickle cell	If indicated by history and/or symptoms											
Sexually transmitted disease	If indicated by history and/or symptoms											
Immunizations	See appendix V											

**Key:**

1 = Provide at this time.

2 = Provide at this time unless done previously.

3 = Assessed through observation and/or through health history/physical.

# Immunization Schedule Recommended by American Academy of Pediatrics

	DTP	Polio	Measles	Mumps	Rubella	Haemophilus <sup>a</sup>	Tetanus-diphtheria
<b>Months</b>							
2	X	X				X	
4	X	X				X	
6	X					X <sup>b</sup>	
12-15						X <sup>b</sup>	
15			X	X	X	X <sup>b</sup>	
15-18	X	X					
<b>Years</b>							
4-6	X	X					
11-12 <sup>c</sup>			X	X	X		
14-16							X

<sup>a</sup> As of March 1991, two vaccines for Haemophilus influenzae infections were approved for use in children less than 15 months of age.

<sup>b</sup> Indicated in many circumstances depending on which vaccine for Haemophilus influenzae infections was previously given.

<sup>c</sup> Except where public health authorities require otherwise.

# Federal and State Quality Assurance Requirements HMA Must Meet as Administrator of the HealthPASS Program

## Quality Assurance: Federal Contract Requirements

Department of Health and Human Services regulations (42 C.F.R. 434.34) require health insuring organizations serving Medicaid patients to establish quality assurance programs that include:

- peer review of services provided,
- health professionals to review the processes followed in providing health care,
- systematic data collection on services provided and patient outcomes, and
- methods for achieving corrective actions when quality-of-care problems are identified.

In addition, HCFA requires states to

- conduct periodic medical audits to evaluate quality assurance programs and determine whether health care organizations are providing quality and accessible health care to Medicaid recipients,
- implement a statewide utilization system to assess the quality of Medicaid services, and
- contract with a peer review organization for an annual independent external review of the quality of services provided.

## Quality Assurance: State Contract Requirements

Pennsylvania requires HMA to develop a comprehensive quality assurance program to assure delivery of quality cost-effective care to all HealthPASS members. Like traditional fee-for-service health care systems serving Medicaid recipients in Pennsylvania, HMA is required to have the following minimum quality assurance and utilization review measures to help assure quality care is provided:

- physicians, clinics, hospitals, and practitioners must be licensed;
- physicians must have malpractice insurance;
- hospitals must have quality review committees;
- a system must be in place that allows recipients to appeal adverse decisions to the State Office of Hearings and Appeals;
- prior authorization must be obtained for certain procedures;
- recipients must have freedom to choose a primary doctor;
- a medical assistance advisory committee must be available;
- continuous comprehensive utilization review must be done; and
- minimum medical record-keeping standards must be met.

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**Appendix VI  
Federal and State Quality Assurance  
Requirements HMA Must Meet as  
Administrator of the HealthPASS Program**

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In addition, the state requires HMA's quality assurance program to contain certain specific quality assurance and utilization review mechanisms, such as:

- routine medical audits of primary care sites at least once every 2 years;
- production and distribution of quarterly profiles comparing the average medical care utilization rates of the members of each primary care physician to the average medical care utilization rates of other HealthPASS members;
- procedures for informing providers of identified deficiencies, monitoring corrective action, instituting progressive sanctions, an appeal process, and reassessment to determine if corrective action has intended results;
- procedures to ensure adequate discharge planning;
- an assessment process that measures the clinical care provided against formalized standards;
- focused medical care evaluations when indicators suggest that quality may need to be studied;
- a written quality assurance plan, updated at least annually, defining the organization and objectives of the program;
- an annual work plan of expected accomplishments;
- a comprehensive semiannual report on all quality assurance activities accomplished;
- adequate staffing of all quality assurance functions; and
- specific provider credentialing and recredentialing requirements.

# Joint Commission on Accreditation of Healthcare Organization's 10-Step Approach to Quality Assurance

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The Joint Commission uses a 10-step approach to assist health care organizations to effectively monitor, evaluate, and improve the quality of care delivered to its members. The model provides an organized approach to ensure quality assurance activities are performed in a consistent and meaningful manner. The 10 steps are:

1. Assigning responsibility to monitor and evaluate activities.
2. Delineating the scope of care to be provided by the organization.
3. Identifying the most important aspects of care to be furnished by providers.
4. Identifying indicators and clinical criteria to monitor the important aspects of care.
5. Establishing thresholds for the indicators that trigger evaluation of care.
6. Collecting and organizing data to facilitate comparison with the thresholds for evaluation.
7. Evaluating care when thresholds are reached to identify problems or opportunities to improve care.
8. Taking action to improve care or correct identified problems.
9. Assessing effectiveness of the corrective action and documenting the improvement in care.
10. Communicating results to relevant individuals, departments, or services and the organizationwide quality assurance program.



# Comments From Pennsylvania's Department of Public Welfare



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
P.O. BOX 2675  
HARRISBURG, PENNSYLVANIA 17105-2675

Larry A. Olson  
Deputy Secretary for Administration

MAR 02 1993

(717) 787-3423

Mr. David Baine, Director  
Federal Health Care Delivery Issues  
United States General Accounting Office  
ACG/Suite 550  
National Guard Building  
1 Massachusetts Avenue  
Washington, D.C. 20548

Dear Mr. Baine:

This is to provide you with comments on the General Accounting Office's draft report titled "HealthPASS: An Evaluation of a Managed Care Program for Certain Philadelphia Recipients."

For your convenience and as requested by Mr. Ballard, I have enclosed two documents. The first document outlines our comments and reactions to the content and findings of the report. The second document, titled Technical Corrections, identifies inaccurate or misleading information carried in the report.

Thank you for the opportunity to review the draft report and for your cooperation regarding issues identified as a result of our review. We look forward to receiving a copy of your final report in the near future.

Best Regards,

A handwritten signature in cursive script, appearing to read "Larry Olson".

Larry A. Olson

Enclosure

**Appendix VIII  
Comments From Pennsylvania's Department  
of Public Welfare**

**Pennsylvania Department of Public Welfare's Response  
to the U.S. General Accounting Office Draft Report**

**"HealthPASS: An Evaluation of a Managed Care Program  
for Certain Philadelphia Recipients"**

The Department of Public Welfare (DPW) appreciates the opportunity to respond to this draft report. We recognize that the focus of this report was confined to several specific aspects of the HealthPASS Program and is intended to be presented as information on these issues to Congress. However, we believe it is important that your report present its findings in the broader context. The current HealthPASS contractor, Healthcare Management Alternatives, Inc. (HMA), has been providing high quality, cost effective services to Medicaid clients in south and west Philadelphia since July 1, 1989. Because of the HealthPASS Program more than 80,000 people now have guaranteed access to health care from their own physician. The program has saved the federal and state governments approximately \$66 million since July 1989.

The Pennsylvania Health Insuring Organization (HIO) Program, known as HealthPASS, was originally designed to maintain or improve access to and the quality of medical services provided to Pennsylvania's medical assistance recipients while reducing health care expenditures for both the state and federal governments. An HIO is defined by the Code of Federal Regulations, 42 CFR Section 434, as an entity that pays for medical services provided to recipients in exchange for a premium or subscription charge paid by the agency and assumes an underwriting risk. HIOs may not be providers of direct care, but serve as fiscal intermediaries. It is critical to understand the definition and function of an HIO when developing expectations for the program.

The fee-for-service (FFS) system is the benchmark that is used to determine the success of HealthPASS in fulfilling its goals. All of the many external assessments conducted to date have concluded that HealthPASS has been successful in reaching these goals. DPW has ensured that HealthPASS meets these goals by establishing minimum quality assurance standards which have continued to be refined to reflect current state-of-the-art quality assurance programs. Recipient education and outreach activities are a primary program component. Enhanced safeguards are in place to ensure the contractor's financial viability in order to protect the state and federal governments, providers, and recipients from risk. Rates have been negotiated that have resulted in significant savings to the state and federal governments.

All external assessments conducted document the performance of HealthPASS and its success at controlling service utilization without reducing quality of care or decreasing access; fulfilling its objectives of fostering cost efficient use of care through authorizations; and ensuring effectiveness of the case management function. External assessments of performance note that the HIO's quality assurance activities, including MIS System and data collection techniques, have improved greatly, and that realistic thresholds which trigger further action to ensure quality patient care have been established. A 1991 study also found that mortality rates, a fundamental indicator of quality, were lower under the HealthPASS Program.

**Appendix VIII  
Comments From Pennsylvania's Department  
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As the HealthPASS Program has matured, DPW and HMA have invested extensive energy to ensure that real or perceived barriers to care are removed. Special initiatives have been developed and implemented in an attempt to effect positive changes in health outcomes. Over the last three years DPW has worked with HMA to develop innovative approaches to preventive health care that benefit our clients. The following are examples of unique services offered to HealthPASS clients, which are not part of the regular FFS Program. Your report alludes to some of these services.

- o A lay home visitors program to assist pregnant women in getting quality prenatal care, resulting in nearly 80 percent of the enrollees having full-term infants;
- o A special breast cancer screening program for high risk Southeast Asian women;
- o A school-based health clinic for middle school students;
- o New community asthma and tuberculosis education programs;
- o Educational documents concerning preventive health care issues and problems; and
- o A toll free 24-hour hotline to answer client questions.

However, despite these initiatives, effecting changes in behavior and health status is not a science. Some initiatives may be more successful than others, and it may take years to see the subtle effects of some initiatives. The Department cannot reasonably expect significant changes in health status in only a few years. The Department and HMA will continue to refine the HealthPASS Program as times and situations in the overall environment change.

The GAO Report generally confirms the success of the HealthPASS Program in meeting its goals in most of the areas reviewed. The report concludes that HealthPASS has maintained a level of prenatal and obstetrical care similar to the Medicaid FFS system. It also recognizes the extensive quality assurance program that HealthPASS has in place, as well as the extensive efforts the Department and HMA have undertaken to increase the use of prenatal care, to improve pregnancy outcomes, and to expand EPSDT screening and treatment of children through outreach and other special initiatives. It also outlines HMA's proactive interaction with the Women, Infants and Children (WIC) Program to try to aid our clients in accessing WIC services.

The Department does have a number of specific comments on the report as follows. Our greatest concern is what we believe to be erroneous conclusions about the EPSDT screening performance of HealthPASS. We believe the methodology used to reach the conclusions in the report is faulty and that the report fails to measure HealthPASS's performance against the proper standard--the FFS performance.

OBSTETRICAL CARE

The GAO has determined that HealthPASS members are receiving timely and appropriate pregnancy-related services when they access care. In fact, the report states that, based on the GAO's HealthPASS sample, for almost 99 percent of the women, providers meet the obstetrical medical guidelines established by American College of Obstetricians and Gynecologists (ACOG) when providing pregnancy-related care. The level of care is at least equal to the level found in FFS Medicaid. The GAO's own consultant states that providers' medical records reflect a constant awareness of high risk factors but many women fail to seek prenatal care in the first trimester or fail to return to periodic follow-up visits. This area needs to clearly state that the classification index used to determine prenatal care obtained reflects the action that is controlled by the patient, i.e. scheduling of prenatal visits; scheduling follow-up visits; and scheduling postpartum visits.

While the Department is not pleased with the significant number of women who are not receiving early prenatal care in both HealthPASS and FFS, it is important to recognize certain realities. Neither the Department nor HMA can force our clients to access the care available to them. The Department and HMA can, and have, made a concerted effort to ensure that real and perceived barriers to access to care are minimized, which is the primary focus for many of the HealthPASS prenatal care initiatives. The Department's goal has been that prenatal care special initiatives and outreach activities would result in women accessing prenatal care earlier and more frequently. The Department will continue to ask HMA to evaluate the effectiveness of its initiatives and design new initiatives to improve use of prenatal care.

PREVENTIVE CARE

The Department's most serious area of concern with the GAO report surrounds the conclusions on preventive care for children and the questionable methodology used to draw those conclusions. The GAO's review methodology is based on evaluations conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as part of the medical audit of HealthPASS. The GAO should have conducted a separate and balanced audit of medical records to determine what differences may exist between fee-for-service and HealthPASS preventive care patterns including EPSDT, sickle cell, and lead screening rates.

The GAO's review methodology is flawed because it does not address the following critical issues:

- A comparison of its FFS counterpart;
- The member's length of uninterrupted enrollment in HealthPASS;
- The fact that any enrolled EPSDT screener can perform the screens; therefore, all medical records for every child must be evaluated, regardless of the place of service, in order to develop a comprehensive evaluation;

**Appendix VIII  
Comments From Pennsylvania's Department  
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- The child's age and health status (certain treatments are inappropriate for sick children);
- The client's length of enrollment with one specific primary care physician (PCP); and
- The JCAHO assessment methodology relating to certain indicators is an assessment of presence or absence of an indicator versus an assessment or judgement of treatment provided or not provided.

**EPSDT.** One major component of preventive care is Early and Periodic Screening, Diagnosis and Treatment (EPSDT). As previously mentioned, the Department has serious concerns and believes that the GAO's review methodology and conclusions are questionable. In addition, the report does not provide sufficient weight to the issue of parent compliance. While the report alludes to the high "no show" rate, it should more clearly reflect the important role of parents and guardians in keeping their child's health care appointments.

The GAO report does not adequately address the attempts by the Department and HealthPASS to remove barriers to accessing EPSDT screens. In HealthPASS, any qualified EPSDT screener can perform the screen and the PCP's authorization is not required. HMA has put forth considerable effort in its EPSDT education and outreach initiatives. Provider newsletters and client brochures and mailings stress the importance of accessing EPSDT services and preventive care. Automated Health Systems, Inc. (AHSI), the Department's EPSDT contractor, is responsible for scheduling medical assistance children in the FFS Program for EPSDT screenings. To enhance HealthPASS clients' access to these services, the Department requires AHSI to also schedule HealthPASS members for EPSDT screening services. This is in addition to screens scheduled by HMA and PCPs. Finally, HMA has and will continue to expand its proactive involvement in the overall care of its enrollees as evidenced in part in the GAO report.

**SICKLE CELL.** This service is also part of the EPSDT screening process. With regard to sickle cell testing, the Department has the same concerns regarding the GAO's review methodology and conclusions. The JCAHO methodology is an assessment of presence or absence of specific indicators and does not assess or evaluate any treatment or test provided or not provided. The EPSDT screening schedule (Appendix IV of the GAO Report) indicates that sickle cell testing is to be performed if indicated by history and/or symptoms. The GAO did not present any evidence that the level of sickle cell testing is not appropriate to the history and symptoms documented in the records reviewed by the JCAHO. Furthermore, since May 1990, Philadelphia requires newborns to be tested for sickle cell disease prior to the child's discharge from the hospital. However, the hospital is not required to forward the result of the test to the HealthPASS PCP. HMA is currently evaluating the feasibility of linking the hospital information to the PCP.

**LEAD SCREENING.** This service is also part of the EPSDT screening process. As discussed previously, the Department has concerns surrounding the GAO's review methodology and conclusions about preventive care and screenings. In addition, the Department is concerned because the JCAHO report reflects only

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the presence or absence of a lead screen test. The JCAHO did not determine the need for a lead screen test based on symptomology or screening schedules. The GAO report does not present a fee-for-service comparison which is the benchmark by which HealthPASS' success in reaching its goals is determined.

**PHYSICIAN CREDENTIALING**

The Department was surprised by the GAO's comments regarding physician credentialing. The contracting with providers for HealthPASS-covered services is governed by the Department's original waiver. HMA must contract with the same types of providers using the same eligibility criteria as the regular Medical Assistance Program. All providers in and near the HealthPASS area who currently participate in the Medical Assistance Program are offered contracts. In addition, providers outside of this area that serve a significant volume of HealthPASS recipients may also contract with HMA. Therefore, information obtained from the referenced data banks could not be used to preclude a provider from participating in HealthPASS.

However, the Department recognizes that this information may be most valuable during the recredentialing process when it is used in conjunction with other provider performance indicators such as the number of client complaints and results of HMA's provider audits. The Department will recommend that HMA use such resources, as available, in its recredentialing process.

Attachment I outlines the credentialing requirements of the regular Medical Assistance Program and the minimum credentialing criteria set forth under the HealthPASS Program.

**CONCLUSIONS**

The Department acknowledges that there is much to be done to improve the use of prenatal care, pregnancy outcomes and EPSDT screening and follow-up for children in both the HealthPASS and FFS Programs. Pennsylvania has made improving access and services to pregnant women and children a priority for the Medical Assistance Program over the past several years. We continue to develop new approaches to address the issues of underenrollment of eligible clients, failure to access appropriate and timely medical services, and "no shows" to scheduled appointments. But this is not an easy problem to address with a population that has many social and economic issues in their lives that often impact on the interest or ability to seek preventive health care. The HealthPASS area of south and west Philadelphia is affected by all the socio-economic ills that adversely affect health status.

The Department is committed to ensuring that the HealthPASS Program continues to focus on the prevalent health issues of our most vulnerable citizens. The Department and HMA will continue to:

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Comments From Pennsylvania's Department  
of Public Welfare**

- Ensure that the HealthPASS Program satisfies the original goals of maintaining or improving access to and the quality of medical services while reducing health care expenditures;
- Evaluate the feasibility of other prenatal and preventive care initiatives;
- Focus on special initiatives to address preventive health care; and,
- Evaluate the feasibility of sharing patient information with WIC if the GAO is successful in convincing HCFA to permit the sharing of the information.

ATTACHMENT I

HEALTHPASS MINIMUM QUALITY ASSURANCE AND UTILIZATION REVIEW REQUIREMENTS

The Contractor shall implement and maintain a quality assurance and utilization review system which will:

- Ensure that health care is provided as medically necessary in an effective and efficient manner;
- Assess the appropriateness and timeliness of the care provided;
- Evaluate and improve, as necessary, access to care and quality of care with a focus on improving patient outcomes; and
- Focus on the clinical quality of medical care rendered to enrollees.

This system will include, at a minimum:

- A) Routine medical audits of PCP sites at least once every two years.
- B) Routine medical audits of each of the other participating provider types. The greater of one or 10% of each provider type identified in the "Number of Providers" report carried in the Contractor's Monthly Operating Reports (excluding PCPs) shall be audited annually.
- C) Production and distribution of quarterly profiles comparing the average medical care utilization rates of the enrollees of each PCP to the average medical care utilization rates of other HIO enrollees.
- D) Analysis of quarterly utilization profiles and follow-up of under-utilization and over-utilization based on established standards.
- E) Procedures for informing providers of identified deficiencies, monitoring corrective action, instituting progressive sanctions, an appeal process, and reassessment to determine if corrective action has intended results.
- F) Procedures for prompt follow-up of reported problems and complaints involving quality of care issues.
- G) Procedures for monitoring the quality and adequacy of medical care including: a) assessing use of the distributed guidelines; and b) possible under-treatment/under-utilization of services.
- H) Review of hospital mortality reports.
- I) Procedures for prospective and concurrent review of inpatient utilization.
- J) Procedures to ensure adequate discharge planning.
- K) Standards of clinical care in the form of a written, professionally developed and accepted expression of desired performance or behavior by a provider under a specific set of circumstances.



ATTACHMENT I

HEALTHPASS MINIMUM QUALITY ASSURANCE AND UTILIZATION REVIEW REQUIREMENTS

Page 2

- L) Protocols which represent an accepted step-by-step set of instructions to achieve the standards of care which include but are not limited to protocols for case management and obstetric care including a requirement that patients be referred to obstetricians or certified nurse midwives at the first visit at which pregnancy is determined.
- M) Guidelines for the management of selected diagnosis and basic health maintenance.
- N) Procedures for gathering and trending data.
- O) Distribution of standards, protocols, and guidelines to all providers.
- P) Standards for medical record keeping requirements which equal or exceed the standards contained in Section 1101.51 of the Medical Assistance Manual and medical record keeping standards adopted by the Department of Health.
- Q) A quality assessment process which measures the clinical care provided to enrollees against formalized standards.
- R) Focused medical care evaluations which are employed when indicators suggest that quality may need to be studied.
- S) Problem-oriented clinical studies of individual care.
- T) A written quality assurance plan, updated at least annually, which defines the organization and objectives of the quality assurance program.
- U) An annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed.
- V) A comprehensive, detailed semi-annual report on all quality assurance activities including studies undertaken, results, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.
- W) Adequate staffing of all quality assurance functions.
- X) Specific provider credentialing and recredentialing requirements.
- Y) A plan to gather baseline data on the health status of targeted recipients including a periodic assessment of health outcomes at specified intervals. The plan must focus on maternal and child health initiatives in 1991, and expand to include cardiovascular disease initiatives in 1992, diabetes mellitus in 1993, and chemical dependency in 1994.

**Appendix VIII  
Comments From Pennsylvania's Department  
of Public Welfare**

**Pennsylvania Department of Public Welfare's Response  
to the U.S. General Accounting Office Draft Report**

**"HealthPASS: An Evaluation of a Managed Care Program  
for Certain Philadelphia Recipients"**

**TECHNICAL CORRECTIONS**

**Executive Summary**

The report indicates that recipients may select to enroll in either HealthPASS or one of the three HMOs. This is not accurate. Two HMOs are under contract with the Department within the HealthPASS service area: 1) Keystone Health Plan East; and 2) Greater Atlantic Health Services.

**Chapter 1**

**Page 15** The report states that of the approximate \$4.4 billion paid by Pennsylvania for Medicaid services, \$211 million is for the HealthPASS area and the federal share was about 57 percent. The \$211 million represents payments for the HealthPASS contract, not the entire area which includes HMOs and some fee-for-service dollars. The federal share was 48 percent.

**Page 17** The statement that fee-for-service clients "...use other medical and hospital services without prior authorization" is not completely accurate. Fee-for-service requires the prior authorization of certain dental services and medical equipment. The Department also requires the precertification of all elective surgery.

**Page 17** Each year the state and the HealthPASS administrator negotiate a fixed percent, not rate, to be paid the administrator for each member enrolled in the program.

**Page 18** The statement that HMA incurs a loss up to a limit specified in its contract is inaccurate. The contract between the Department and the HIO does not place a limit on loss that can be incurred.

**Page 18** The statement, "In July 1991, a limit of \$1,000 was established as the total amount that the primary care physician's fund can be charged for each patient", is misleading. This needs clarification to explain that the \$1,000 does not represent a cap on referral services.

**Chapter 2**

**Page 38** The GAO states that the Department submitted to HCFA a proposal to provide WIC with the names and other pertinent information of all new HealthPASS members who are pregnant and the names of the children under age five. The Department discussed this issue with

**Page 2**  
**Technical Corrections**

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HCFA and submitted a similar HMO proposal to HCFA. The proposal was subsequently rejected. The Department agrees with the GAO's recommendation that the Secretary of Health and Human Services allow the provision of the name of HealthPASS members to WIC.

**Chapter 3**

**Page 43** The statement "HMA lowered from \$4,000 to \$1,000 the maximum amount that a primary care physician's referral services fund would be charged for each patient sent to a specialist" is misleading. This needs to clarify that the dollar reduction does not reflect a cap on referral services.

**Chapter 4**

**Page 50** The GAO report referencing quality assurance and utilization review measures to assure that members receive quality care as evidenced in Appendix VI is inaccurate. Attachment I outlines all of the HealthPASS minimum quality assurance and utilization review components required of the HealthPASS contractor.

**Appendix VIII  
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ATTACHMENT I

**PHYSICIAN CREDENTIALING CRITERIA**

<u>HealthPASS</u>	<u>Medical Assistance Fee-For-Service</u>
Current Pennsylvania license to practice medicine.	Current Pennsylvania license to practice medicine.
Provider agreement in place with DPW.	Provider agreement in place with DPW.
Provider agreement in place with HMA.	
Current Drug Enforcement Authority certification.	
Current professional liability insurance.	
Attestations confirming Continuing Medical Education (CME).	
Attestations confirming hospital admitting privileges.	
On-site evaluation of facilities.	
Approval of HMA's Medical Director.	
Approval of the Provider Affairs Subcommittee.	
Approval of the Quality Assurance Committee.	
Approval of HMA's governing board.	

# Comments From Healthcare Management Alternatives, Inc.



HEALTHCARE MANAGEMENT ALTERNATIVES INC.

A. J. HENLEY  
CHIEF EXECUTIVE OFFICER

February 26, 1993

Mr. Michael J. Stepek  
U. S. General Accounting Office  
Philadelphia Regional Office  
841 Chestnut Street  
Suite 760  
Philadelphia, Pennsylvania 19107

Dear Mr. Stepek:

Enclosed, as discussed in our exit interview yesterday, is a copy of HMA's responses to the GAO draft report. We are pleased with the objectiveness of the report.

As we have mentioned at the interview, HMA has been in contact with Automated Health Systems, Inc. operators of the EPSDT program for the State of Pennsylvania. Today, we were able to obtain data from them showing that for calendar year 1992, the percentage of HealthPASS eligibles screened was 44%, compared to 32% for the Philadelphia Medicaid population. We will forward supporting documentation to you within the next few days.

I have enclosed documentation (Attachment A) regarding the low, city-wide percentage of participation in the WIC program. Also included is a reference to the Philadelphia Health Department study which found that 70% of Latino children in a North Philadelphia area were not appropriately immunized (Attachment B).

In closing, your team's efforts and insights were greatly appreciated. Should you have any further questions, do not hesitate to contact me at 215/581-5950.

Sincerely,

A handwritten signature in black ink that reads 'A J Henley'. The signature is written in a cursive style.

A. J. Henley  
Chief Executive Officer

encl.

5070 PARKSIDE AVENUE SUITE 6200 PHILADELPHIA PA 19131 215 473 7511 FAX 215 473 0446

**EXECUTIVE SUMMARY**

Healthcare Management Alternatives, Inc. (HMA), is committed to delivering quality care to its members. Our approach incorporates the development of targeted outreach and health education programs that improve our members' access to care. The problems in elevating our HealthPASS members' health status are rooted in decades of poverty and remain deeply entrenched. While we work diligently and creatively to reverse these debilitating conditions, it may be years before HMA's programs make a significantly quantifiable difference or can be fully evaluated.

Our experience, however, has convinced us that health care intervention should be an integral part of a comprehensive, community revitalization effort. Solving complex health problems cannot be accomplished in isolation. The strategies must include finding remedies for the causes of deteriorating family support groups, crumbling community structures, and inadequate housing. All of these conditions speak to the immediate need for an integrated approach to delivering health and welfare services and for ensuring economic opportunity for inner-city residents.

An example of such an approach is HMA's effort in the Mantua area to improve the quality of life for thousands of pregnant women and newborns who live in lead-contaminated housing. Through financial support of local community organizations and governmental agencies, HMA is serving as the catalyst for change in this economically distressed area. The project, which establishes medical and day care services, focuses upon early identification of pregnant women and environmental assessment for lead contamination as well as remedial actions in their homes during the prenatal period. All of these activities will be linked to literacy and job training programs. The results, we anticipate, are healthier lifestyles for the Medicaid population in this West Philadelphia community.

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The GAO report references how socioeconomic factors affect health care and the high degree of correlation between poverty and health. Nowhere is this more tragically demonstrated than in the case of infant mortality. Poverty also impacts adversely on federal programs like WIC and EPSDT, where eligible poor children remain chronically underserved. Unfortunately, in spite of HMA's many documented efforts, we have made limited progress in these areas.

The GAO report does not specifically mention the 401 HealthPASS women who participated in HMA's Lay Home Visiting program. Of the women served over a one-year period, the 5.9% of low birth weight babies was extraordinarily low. This compares favorably to the city-wide rate of 15.3%, and West and South Philadelphia rates of no less than 20% for non-white, low birthweight babies. This HMA initiative has clearly made a difference.

The GAO did not conduct comparative studies between HealthPASS and fee-for-service in regard to immunization rates and WIC enrollments. However, according to the report, 74% of HealthPASS children and mothers enrolled in WIC. This is markedly higher than a city-wide rate of 50%. Similarly, HealthPASS immunization rates (62%) compare favorably with the estimated 30 to 60% of Philadelphia's pre-school children -- at all income levels -- who are immunized. Moreover, HMA increased the absolute number of EPSDT screens by 18.5% from 1990-1991. According to recent data from Automated Health Systems, Inc., which operates the EPSDT program for the state, the percentage of HealthPASS eligibles screened in 1992 was 44%, compared to 32% for the Philadelphia Medicaid population.

HMA is taking immediate steps to review the GAO recommendations regarding physician credentialing. We agree with the recommendation that HMA should have access to the National Practitioners Data Base (NPDB). HMA currently attempts to obtain similar information from a provider application, but the process would be greatly enhanced by this added resource. While our Quality Assurance Program has been termed by the Joint Commission as "state of the art," we welcome the GAO's recommendation. For more detail

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about HMA's current credentialing practices which meet federal and state requirements, please refer to our response on Chapter 4.

HMA has included additional specific comments at the end of each of the chapters in the GAO report.

**Chapter 2: Obstetrical Care Meets ACOG Guidelines When Women Seek It, but Pediatric Care Needs Improvement.**

**HMA Comments**

As part of HMA's efforts to increase EPSDT participation, it should be noted that in September 1990, HMA sponsored an EPSDT Summit meeting with 38 EPSDT/HealthPASS providers in attendance. The Summit was favorably evaluated.

With regard to the GAO study on infant mortality, several other studies document no significant differences between Medicaid managed care and fee-for-service plans. Research indicates the highest determinant of infant death is poverty. Infant mortality has been called a social problem with health consequences. The specific conditions most often associated with poverty confirm the truth of this statement. Low maternal education levels, young maternal age, single marital status, and limited financial resources have all been shown to increase the mortality rate during the first year of life. Clearly, many of these factors are directly attributable to poverty, which sets up a chain of events that ultimately leads to infant mortality.

HMA does not presume to solve the issue of poverty in West and South Philadelphia, but it has undertaken several initiatives to overcome real and perceived barriers to prenatal care. While most of these are documented in the GAO report, we would like to focus attention on our Lay Home Visiting program.



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The Visiting program served 401, mostly African-American, pregnant women during the last contract year (May 1991-May 1992). Under the supervision of a nurse, community women are trained to make home visits during the prenatal time and postnatally up to the baby's first birthday. The home visitors' roles are fourfold: outreach, education, support and linkage to obstetrical appointments and existing programs (WIC, EPSDT). This comprehensive approach is consistent with recommendations in the report of the Public Health Service Expert Panel on the Content of Prenatal Care (1989) and was recently cited by the National Commission to Prevent Infant Mortality as "... one of the best hopes in reducing infant mortality."

The 5.6% of low birth-weight babies in HMA's Lay Home Visiting program is extraordinarily low. This rate compares favorably to the city-wide rate of 15.3% and rates of no less than 20% for non-white, low birth-weight babies in South and West Philadelphia. Program participants are all enrolled in WIC and 80% of the infants, six months or younger, have been immunized.

HMA continually works on improving WIC enrollments and immunizations. Despite federally-funded programs like WIC and EPSDT, eligible children remain chronically underserved. The Pennsylvania Department of Health (State Data Center, Division of Special Foods Programs) reports in Philadelphia only 50% of the target population were enrolled in WIC. This compares to 74% of HealthPASS children. Similarly, EPSDT has been underutilized by both the HealthPASS and the fee-for-service medicaid population. While the GAO reports that 62% of HealthPASS children in the Joint Commission EPSDT findings have been immunized, this compares favorably against city-wide estimates of 60% of children at all income levels not fully immunized, with rates as low as 30% in some areas. According to a study conducted by the Philadelphia Health Department released in September 1990, seventy percent (70%) of preschool-age Hispanic children residing in North Philadelphia were not fully immunized.

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The GAO report acknowledges EPSDT screens are under-reported, but it does not note that HealthPASS screens increased 18.5% from 1990 to 1991 and 5.47% from 1991 to 1992. The absolute number of screens has increased in spite of the decrease of the number of HealthPASS enrollees under age 21 (and therefore eligible for EPSDT) during the same time period by over 10%. Compared with the city-wide percentage (32%) of EPSDT eligibles screened in 1992, the HealthPASS percentage of 44% is significantly higher.

The lack of an EPSDT examination may not indicate a child received inadequate preventive care. Many excellent providers such as Children's Hospital of Philadelphia, HMA's largest pediatric provider, are well known for their compliance with quality of care guidelines.

Finally, it should be emphasized that HMA is the only managed care plan in the demonstration area which specifically reimburses for EPSDT above and beyond the capitation fee given to pediatric providers. HMA plans to continue its vigorous efforts regarding EPSDT.

**CHAPTER 3: HMA FINANCIAL INCENTIVES ARE DESIGNED TO ADEQUATELY  
COMPENSATE PHYSICIANS.**

**HMA Comments.**

The sentence, "We found, for example, that the number of mammogram referrals increased in 1991 when HMA stopped charging primary care physicians for such referrals," may be misleading. As reported on page 45, the slight increase in women receiving mammograms may be attributed to several factors only one of which was the discontinuance of charging primary care physicians' pools for the service.

On page 43, the last full sentence on the page should be clarified to indicate that the amounts reported are the net deficits for the year rather than cumulative totals.

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**CHAPTER 4: HMA'S QUALITY ASSURANCE PROGRAM MEETS STANDARDS BUT  
PHYSICIAN CREDENTIALING COULD BE IMPROVED**

**HMA Comments.**

HMA agrees with the GAO's findings regarding the HMA Quality Assurance Program. The summary report format does not provide the opportunity to detail all of HMA's QA activities. The description of the mammography program does capture the flavor of our approach to monitoring, identification of issues and corrective action.

It should be noted that Dr. Denise Ross, former Associate Medical Director, is no longer in an "Acting" capacity. She is currently HMA'S permanent Medical Director.

In response to the credentialing comments, it is important to note that HMA currently requires an application that questions the physician about his/her history of sanctions including malpractice denial or cancellation; and licensure and hospital restrictions, limitations, or suspensions. In addition, HMA requires copies of key documents such as Pennsylvania license, DEA certificate, and the malpractice face sheet.

Among other requirements, all physicians must be currently active in the Pennsylvania Medical Assistance Program (as verified on the state MIS system), must not be suspended or terminated from participation in the Medicare Program, and must have current privileges at a participating hospital. Each physician making application goes through the credentialing process during which the application must be approved by HMA's Provider Affairs Subcommittee, a group of physicians that act in a peer review capacity.

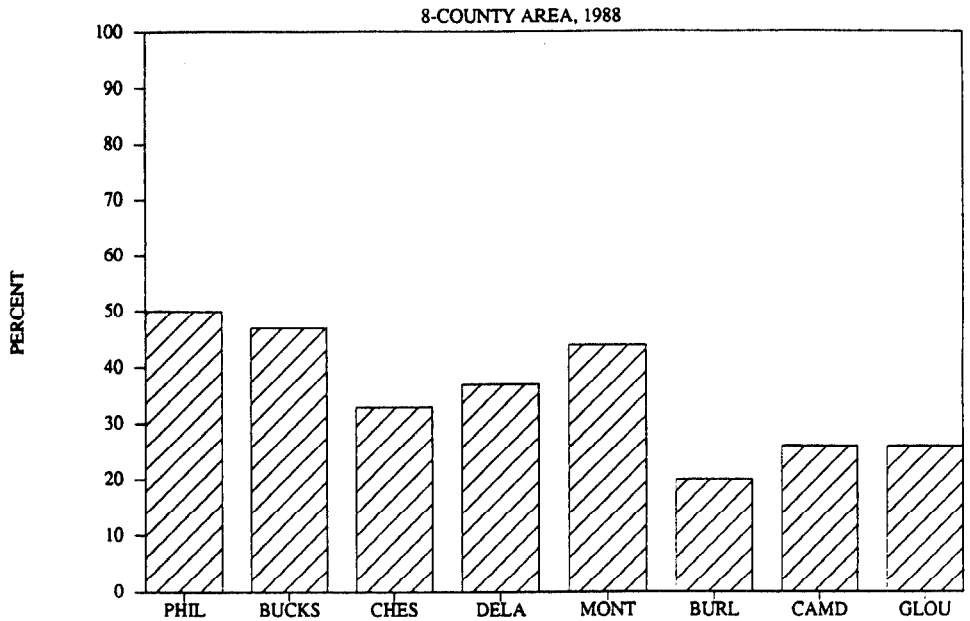
As noted, HMA is in agreement with the GAO's recommendation that Congress permit HMA to access data from the National Practitioners Data Base (NPDB). This information will be used to supplement the data currently collected on the physician application. This is in keeping with HMA's desire to access primary sources of information.

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Based upon the GAO's comments, the NPDB is more comprehensive than the Federation of State Medical Boards. It is our opinion that accessing both data bases might be duplicative. The Provider Affairs Subcommittee has approved our recommendation to pursue access to the NPDB. If HMA's application for access is approved, the peer review committee will include the NPDB data in the formal credentialing process.

ATTACHMENT A

**WIC ENROLLMENT: % OF TARGET POPULATION**



Source: Pennsylvania Department of Health-  
State Health Data Center and Division of  
Special Food Programs;  
U.S. Department of Agriculture, Region II;  
New Jersey State WIC Program

From Targeting for the Future: Health Care is the Philadelphia Region. A report  
to the Pew Charitable Trusts. January 1989.

**Appendix IX  
Comments From Healthcare Management  
Alternatives, Inc.**

ATTACHMENT B  
BACKGROUND AND NEED STATEMENT

Centers during FY 1990.<sup>3</sup> As can be seen, minority groups constituted the vast majority of users and visits. While private insurance paid for 20.3% of the visits, 37.2% were paid for by Medicaid, and 42.5% were categorized as self pay.

The federally funded community health centers are operated by five corporations with nine sites. Collectively they have about 60,000 users, 22.3% of whom are under age 5. Seventy-two percent of the visits are paid for by Medicaid; 19% are self pay. Of the total community health center encounters in 1990, 85% represented those at or below the poverty level; an additional 10.5% were between 100 and 200% of the poverty level. In 1990 the community health centers served 14,633 children aged 0-4. With the City operated District Health Centers and federally-funded CHC's providing services to approximately 170,000 individuals, it is clear that these two sources of health care represent a significant portion of primary care services to poor and uninsured families.

**Immunization Status:**

Immunizations with publicly-purchased vaccines are provided by a network of City Department of Public Health District Health Centers and of neighborhood health centers, federally-funded community health centers and hospital-based pediatric clinics. These centers are shown in Figure 3. Approximately 38% of the children in Philadelphia obtain their immunizations from those providers who receive publicly purchased vaccines. The remainder are given by private physicians.

While 96% of children entering school were found to be fully immunized, data from the 1989-90 retrospective study of two year olds indicate that only 46% of the two year olds in Philadelphia are completely immunized at 24 months of age. In certain areas of the City, immunization levels of two year olds are significantly lower. For example, one recent study of Puerto Rican/Latino children in 18 schools in North Philadelphia found that 70% of the children had not been appropriately immunized by their second birthday. It is clear that outreach is desperately needed to assure immunizations for all children.

Table 3 shows the numbers and types of immunizations given by the public sector network to persons of all ages for the years 1989, 1990, and 1991. Table 4 shows those same data for the 0 to 5 year age group. It should be noted that the huge increase in Hib immunizations in 1991 results from a change in dosing schedule from one to four doses. MMR immunizations reflect first immunizations only. In 1991, 9,190 children under the age of one year received single antigen measles immunizations with publicly purchased vaccine.

	1989	1990	1991
DTP	55,639	64,715	76,915
OPV	45,173	52,699	54,562
MMR*	12,631	18,468	41,477
Me	—	—	16,085
Hib	3,308	13,216	48,057**

\* First dose only.  
\*\* Reflects change in schedule from one to four doses.

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<sup>3</sup>Age-specific data were not available for FY 1991. However relative proportions are assumed not to have changed very much. From The Infant Immunization Initiative Plan submitted by the City of Philadelphia to the U.S. Department of Health & Human Services. February 1992.

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