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MEDICARE MANAGED CARE

Greater Oversight Needed to Protect Beneficiary Rights

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The Honorable Charles E. Grassley
Chairman
The Honorable John Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Jack Reed
United States Senate

Since 1994, enrollment of Medicare beneficiaries in managed care has tripled to 7 million—comprising 18 percent of all Medicare beneficiaries. Beneficiaries who enroll in managed care are entitled to all Medicare-covered services. They also may benefit from lower out-of-pocket costs, additional covered benefits, and less paperwork than their counterparts in traditional fee-for-service Medicare. Unlike fee-for-service providers, however, managed care plans receive a fixed amount per month for each enrolled beneficiary, regardless of the type and number of services they provide. Consequently, plans have a financial incentive to limit beneficiaries' use of health care services. To safeguard access to appropriate covered services, Medicare allows beneficiaries to appeal—first to their managed care plans and then externally—whenever their health plans deny requested care or refuse to pay for services.[1]

Because the appeals process helps safeguard Medicare beneficiaries' right to covered services from managed care plans, you asked us to assess the adequacy of the process, including the recently instituted expedited process. Specifically, you asked us to focus on the appeals process at the plan level, providing information on (1) the appeals process available to beneficiaries when managed care plans deny care or payment for services, (2) beneficiaries' use of the appeals process and the extent to which they are informed of their appeal rights, and (3) the Health Care Financing Administration's (HCFA) oversight of this process.

To conduct our review, we interviewed officials from HCFA; the Center for Health Dispute Resolution (CHDR), HCFA's contractor that reviews plans' appeal decisions; and selected managed care plans. We also reviewed HCFA's 1997 managed care plan monitoring reports and reports by the

[1]Similarly, beneficiaries in fee-for-service Medicare who disagree with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare may appeal the decision.

Office of Inspector General (OIG) in the Department of Health and Human Services (HHS), analyzed the results of a questionnaire sent to all health maintenance organizations (HMO) about their plan-level appeals, reviewed a number of appeals forwarded to CHDR, and collected statistical data from HCFA and CHDR on plan appeals. In addition, we accompanied agency staff on two monitoring visits to plans and visited four HMOs. We performed our work between June 1998 and April 1999 in accordance with generally accepted government auditing standards. (See app. I for details on our scope and methodology.)

Results in Brief

Medicare beneficiaries enrolled in managed care plans have the right to appeal if their plans refuse to provide health services or pay for services already obtained. For example, if a plan denies a beneficiary's request for skilled nursing care or a referral to a specialist, it must issue a written notice that explains the reason for the denial and the beneficiary's appeal rights. Upon receipt of the written denial notice, the beneficiary may appeal and the health plan must reconsider its initial decision. If the plan's reconsidered decision is not fully favorable to the beneficiary, the case is automatically sent to CHDR to review the decision. CHDR may overturn or uphold the plan's decision. A beneficiary is entitled to an expedited decision from the plan, both on the initial request and on appeal, if the standard time for making the decision could endanger his or her health or life. A beneficiary who is dissatisfied with CHDR's decision may appeal further to an administrative law judge (ALJ) and then to a U.S. District Court, provided certain requirements are met.

HMOs reported an average of approximately 9 appeals per 1,000 Medicare members annually between January 1996 and May 1998. HMOs reversed their original denial in about 75 percent of appeal cases. The number of appeals, however, may understate beneficiaries' dissatisfaction with the initial decisions by HMOs for two reasons. First, some beneficiaries may disenroll and switch to another plan or fee-for-service Medicare instead of appealing. Second, some beneficiaries may not appeal because they are unfamiliar with their appeal rights or the appeals process. We found that beneficiaries frequently received incomplete notices that failed to explain their appeal rights; some beneficiaries did not receive any notices. In addition, notices often do not state a specific reason for the denial; as a result, beneficiaries may be uncertain as to whether they are entitled to the requested services and thus be discouraged from appealing. We also found that beneficiaries may receive little advance notice when plans decide to discontinue paying for services, such as skilled nursing care,

which places these beneficiaries at financial risk should they decide to continue treatment during their appeal. In general, beneficiaries who lose their appeals are responsible for the treatment costs incurred after the date specified in the denial notice.

HCFA's oversight of health plans' appeals process has several shortcomings. The agency does not determine whether beneficiaries who were denied services but did not appeal were informed of their appeal rights. It also does not monitor provider groups that contract with health plans. Many of these groups play a key role in the appeals process by issuing denial notices and deciding whether to expedite initial decisions. HCFA has not ensured consistent implementation of the expedited appeals process because it has not issued specific criteria for expedited cases. We found that a group of health plans in one HCFA region had collaborated to develop such criteria. The HCFA regional office subsequently issued these criteria to plans in its region. Finally, HCFA has not used available information to develop more effective plan oversight strategies. The agency is planning to gather plan-level appeals data (similar to the data we collected for this report), but actual data collection may not begin for another year. In commenting on a draft of this report, HCFA agreed that the agency needs to improve its oversight of the appeals process. HCFA cited several initiatives it is currently undertaking to better protect beneficiaries' rights.

Background

In 1998, about 7 million—or 18 percent—of Medicare's 39 million beneficiaries were enrolled in a managed care plan. About 90 percent of Medicare managed care enrollees belong to one of 307 risk-contract HMOs.[2] These plans are paid a predetermined monthly amount for each Medicare enrollee, regardless of the amount of Medicare covered services the enrollee uses. The plans are called "risk" HMOs because they assume the financial risk of providing care for the amount Medicare pays.

Risk HMOs must provide all services covered by fee-for-service Medicare; in many instances, they provide additional services—such as outpatient prescription drugs and routine physical exams. Generally, plans require enrollees to use only providers that contract with the plan and to follow certain procedures to obtain health care services. For example, most plans require enrollees to obtain prior authorization for care either from their primary care physician or directly from the plan. If enrollees do not follow the procedures, plans may not pay for the services.

[2]There are also cost-contract plans, where Medicare pays the actual cost the entity incurs in furnishing covered services less the estimated value of beneficiary cost-sharing, and health care prepayment plans, which are similar to cost-contract plans except that they provide only Medicare part B services.

HCFA Performs On-Site Monitoring of Plans Every 2 Years

HCFA performs biennial on-site performance reviews of each health plan's operations, including the appeals process, to evaluate plan compliance with HCFA regulations. HCFA staff review a sample of appeal cases and evaluate whether the plan met Medicare process and timeliness requirements. Results of the performance review are reported in the monitoring report. The report documents whether a plan met all legal and policy requirements and describes any deficiencies and needed corrective actions.

Class Action Lawsuit Challenges Medicare HMOs Appeal Practice

In November 1993, a class action lawsuit filed against the Secretary of HHS challenged a number of the policies and practices of the Medicare managed care program. As a result of this lawsuit, HCFA is currently under an injunction and order issued by the federal district court that requires Medicare HMOs to give their enrollees written notices that meet certain criteria.[3] Specifically, the order required, among other things, that Medicare HMOs (1) issue denial notices within no more than 5 working days of the request for service or payment and at least 1 working day before the reduction or termination of treatment, (2) clearly state the reason for the denial in the notice, (3) expedite appeals when services are urgently needed (within 3 working days of the request), and (4) continue acute care services until a final appeal decision is issued when the beneficiary requests an expedited appeal.[4]

Since the 1997 court order, HCFA has required each plan to implement an expedited process for decisions on initial requests for health services and appeals of denied health services. Subsequently, the expedited process was mandated along with other appeals procedures and beneficiary protections by the Balanced Budget Act of 1997 (BBA) and further addressed in the Medicare+Choice regulations published in June 1998. A beneficiary may now request an expedited decision if he or she believes that serious adverse health consequences could result from waiting for a decision under the standard process.

[3]Grijalva v. Shalala, 946 F. Supp. 747 (D. Ariz. 1996), Oct. 17, 1996; subsequent judgment implementing the order was issued Mar. 3, 1997.

[4]HCFA appealed the decision of the lower court to the U.S. Court of Appeals for the 9th Circuit, which on August 12, 1998, upheld the lower court's decision. HCFA's second appeal was also denied. On February 10, 1999, HCFA asked the U.S. Supreme Court to review the case.

Medicare Beneficiaries Can Appeal Plan Decisions

Medicare beneficiaries enrolled in managed care plans have a multilevel appeals process available if plans refuse to pay for requested services, refuse to provide requested services, or discontinue or reduce services.[5] Beneficiaries generally appeal to their plan first.[6] If the plan upholds the initial denial, the appeal is forwarded to CHDR for external review and resolution.[7] However, a further appeal to an ALJ and the court is possible. Under certain circumstances, a beneficiary or a health care provider may request that a plan expedite its decision on the initial request and any subsequent appeal.

Appeals Process Starts at Managed Care Plan but Is Subject to External Review

The appeals process may begin when a Medicare member asks his or her plan to provide a service, such as skilled nursing care or a referral to a specialist, or pay for a service already obtained and is turned down.[8] In such instances, Medicare requires plans to issue a written notice that states the reason for the denial and explains the beneficiary's appeal rights. A member has 60 days from the date of the denial notice to ask the plan to reconsider its initial decision.[9] The appeal request, which must be in writing, can be addressed to the member's health plan or the Social Security Administration, which will forward it to the health plan. A member is not required to submit additional information to support or clarify the request. However, health plans must provide their members the opportunity to supply such information.

The plan's reconsideration of its initial decision, the internal portion of the appeals process, must conform to certain requirements. Prior to July 27, 1998,[10] a plan had up to 60 days to complete this process; now a plan must reconsider its initial decision within 30 calendar days if the request is for

[5]Health plans must also have a process for handling beneficiary complaints about quality of services, timeliness of services, and administrative problems. Such complaints, known as grievances, may not be appealed outside the plan. In commenting on a draft of this report, HCFA said that it is developing an additional set of requirements for grievance processes.

[6]Beneficiaries discharged from a hospital by their HMO may appeal to peer review organizations—organizations that include practicing doctors and other health care professionals, under contract to the federal government to monitor the care given to Medicare patients.

[7]CHDR reviews plans' appeal decisions that are not wholly favorable to the enrollee. An independent review of a plan's adverse initial decision is required by 42 C.F.R. 417.614.

[8]All parties to the initial decision have a right to appeal. This includes the member, a representative of the member, a legal representative on behalf of a deceased member's estate, and any other entity determined to have an appealable interest in the proceeding, such as out-of-plan physicians or suppliers.

[9]A member may appeal a denied service or payment for service even if a notice is not issued.

[10]This was the effective date for Medicare+Choice regulations, issued on June 26, 1998.

health care services and within 60 calendar days if it is for payment.[11] The plan representative considering the appeal must not have been involved in making the initial decision. To make a reconsidered decision, the plan representative reviews the initial decision and all other evidence submitted by the beneficiary, beneficiary representative, provider, and health plan.

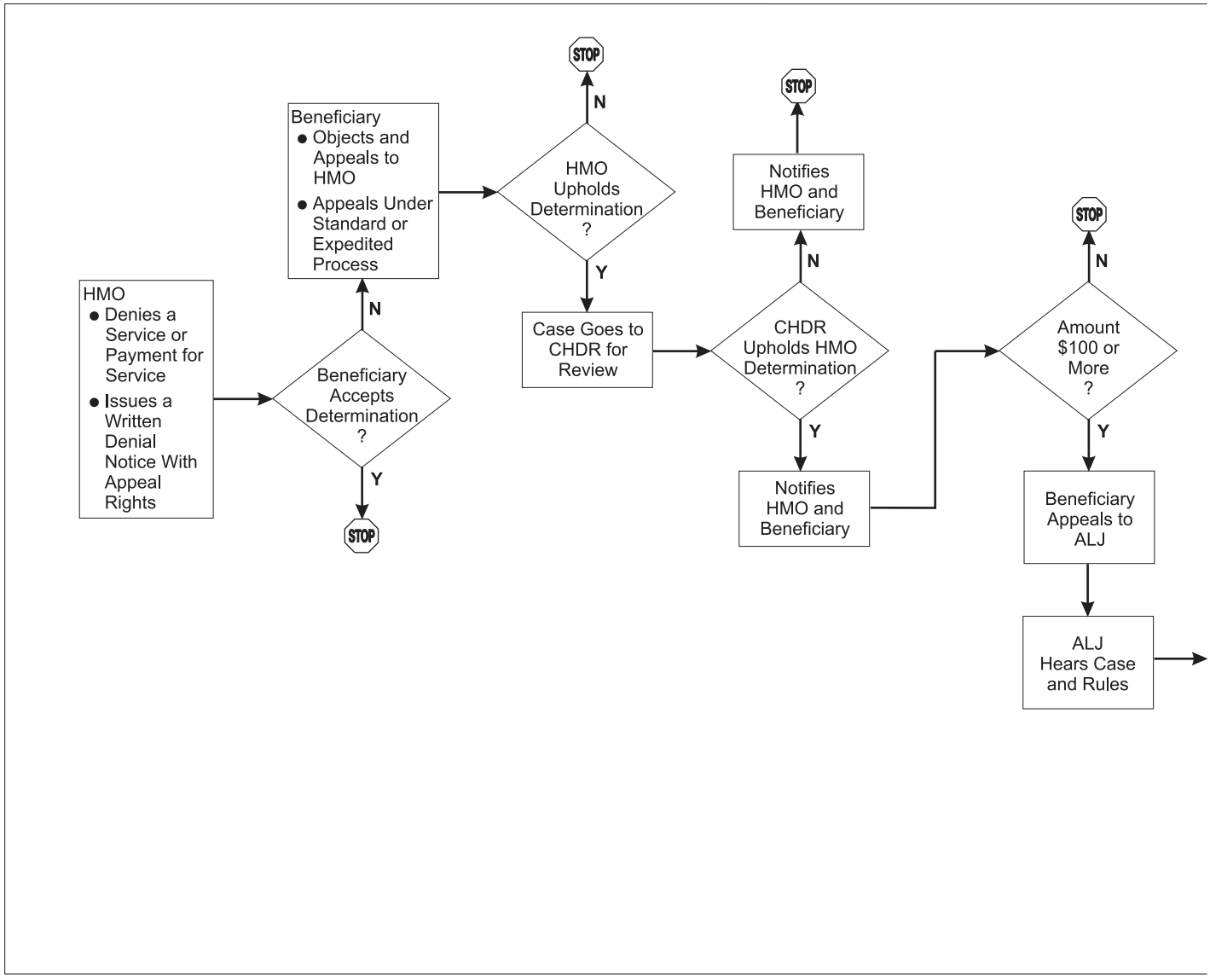
If a plan upholds, in whole or part, its initial denial, it must forward the case to CHDR for external review.[12] HCFA has modified its contract with CHDR requiring CHDR to be held to the same time standards as the plans for processing appeals. (Prior to the change, CHDR had 30 days to consider the case, make its ruling, and inform the beneficiary of its decision.) If CHDR upholds the plan's denial, the beneficiary can request an additional appeal before an ALJ, provided the services in question cost at least $100.[13] A beneficiary may ask that the Social Security Departmental Review Board review a denied ALJ appeal. If the board declines to review the ALJ decision or denies the appeal and the amount of the services in question is greater than $1,000, the beneficiary may request a hearing in U.S. District Court. A beneficiary who loses an appeal is responsible for the cost of any disputed health care services that he or she obtained. Figure 1 shows the Medicare appeals process, step by step.

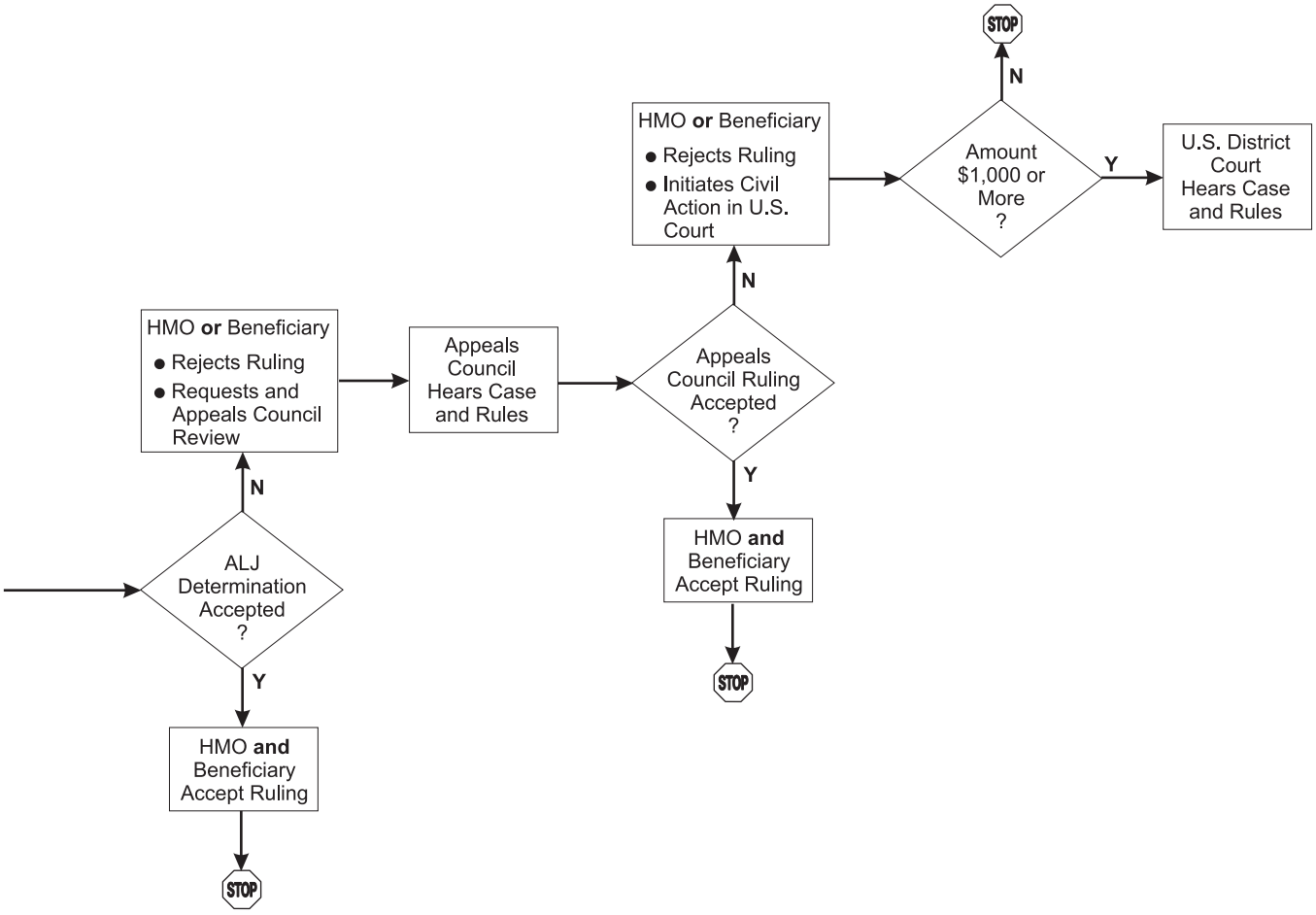
[11]HCFA also established new processing time frames for initial determinations. Plans must make these decisions within 14 calendar days for request of health services and 30 calendar days for payment of services. The time frames can be extended up to an additional 14 calendar days, if such extension would be helpful to the beneficiary.

[12]For calendar years 1996 and 1997 and the first 7 months of 1998, CHDR received 5,543, 8,152, and 6,334 appeal cases, respectively.

[13]The beneficiary has 60 days from the date of HCFA's reconsideration determination to request a hearing before an ALJ.

Figure 1: Medicare Appeals Process





Beneficiaries or Their Physicians Can Request an Expedited Decision

Since August 28, 1997, HCFA has required managed care plans to establish and maintain an expedited process covering both initial decisions and internal appeals. Medicare beneficiaries can request expedited decisions when they believe that waiting the standard time for an initial decision or an appeal of the initial decision could seriously jeopardize their health or

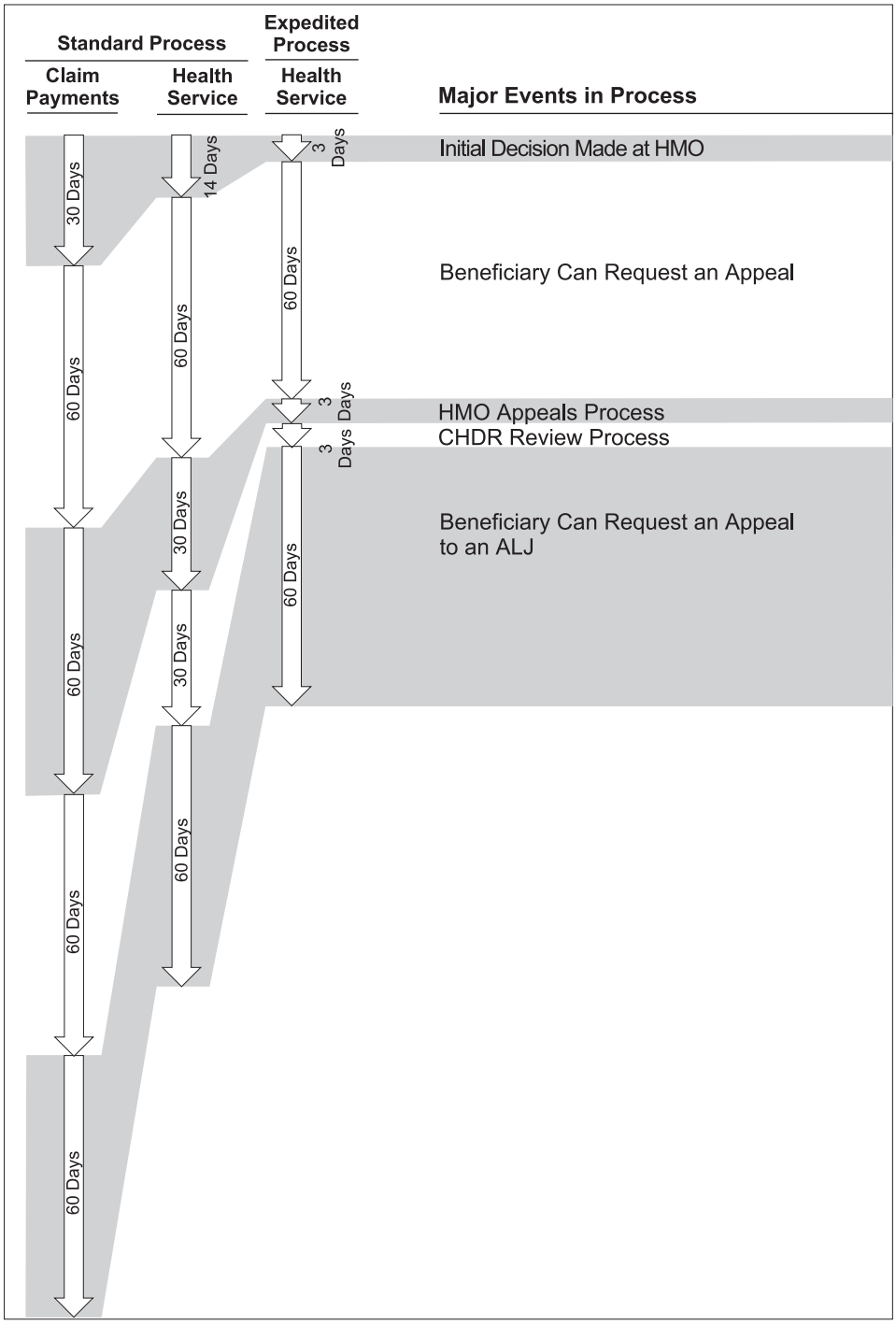
life. If a beneficiary makes the request, the plan determines whether the expedited process is warranted. If a physician makes the request on behalf of a beneficiary or concurs with the beneficiary's request, the plan must expedite its decision. Generally, health plans must make the expedited decision within 72 hours following the request.[14] An expedited decision that is adverse to the beneficiary must be forwarded to CHDR within 24 hours.[15] CHDR is required to process the expedited cases within 72 hours.[16] Figure 2 provides the time intervals for major events in the process.

[14]Certain exceptions allowed plans an extension of up to 10 additional working days. This was redefined to 14 calendar days, effective July 27, 1998.

[15]CHDR received 870 expedited appeal cases in 1997 and 1,755 expedited appeal cases during the first 7 months of 1998.

[16]Prior to August 1998, CHDR had up to 10 days to process expedited cases.

Figure 2: Elapsed Time for Major Events in the Appeals Process



Beneficiaries' Limited Use of the Appeals Process May Understate Dissatisfaction With HMOs' Initial Decisions

HMOs that responded to our survey reported receiving approximately 9 appeals annually per 1,000 Medicare members.[17] However, this number may understate beneficiaries' dissatisfaction with HMOs' initial decisions. First, dissatisfied beneficiaries may disenroll and switch to another plan or fee-for-service instead of appealing. Second, beneficiaries may be unfamiliar with their appeal rights or the appeals process. Plans may not always issue the required notices or may omit an explanation of beneficiaries' appeal rights. In other cases, beneficiaries may not appeal because the notices list nonspecific reasons for the denial.

Annual Appeals Per 1,000 Beneficiaries Varied Among HMOs

The number of annual appeals per 1,000 Medicare beneficiaries varied among HMOs and may be rising. The 242 Medicare HMOs that responded to our recent survey reported an average of about 9 appeals annually per 1,000 beneficiaries between January 1996 and May 1998 (see table 1). Generally, plans overturned nearly three-quarters of the requested appeals. Those not overturned were submitted to CHDR for further review and consideration. Between August 28, 1997, and December 31, 1997, plans expedited 861 appeals.[18] During the first 5 months of 1998, plans expedited 1,548 appeals.

Table 1: Medicare Risk HMO Internal Appeals, 1996 to May 1998

Year	Number of HMOs[a]	Percentage of all risk HMO enrollees	Average monthly enrollment (millions)	Total appeals	Annual number of appeals per 1,000 Medicare enrollees
1996	160	84	2.7	22,437	8.2
1997	223	85	3.9	31,844	8.1
1998[b]	242	89	4.8	21,138	10.5

Note: Table reflects responses from 242 HMOs that completed GAO's questionnaire on internal appeals.

[a]Number of HMOs that responded to our survey in 1998 and were active in given year.

[b]Includes first 5 months of 1998.

Source: GAO survey of Medicare risk HMOs active as of May 31, 1998.

[17]In July 1998, we surveyed all (307) HMOs with active Medicare enrollment as of May 31, 1998. Eighty percent of the HMOs, representing about 5 million (89 percent) of the Medicare beneficiaries enrolled in HMOs, responded to our questionnaire. During 1996, 1997, and the first 5 months of 1998, these HMOs reported receiving about 22,000, 32,000, and 21,000 appeals, respectively. Although the number of appeals increased from 1996 to 1997, the number of managed care enrollees also increased. Consequently, the average rate of appeals per 1,000 members was approximately the same in both years.

[18]About two-thirds of the plans responding to our survey reported the number of requests received that they had expedited. On average, these plans expedited about one quarter of the requests.

The number of annual appeals per 1,000 Medicare beneficiaries among HMOs ranged from 0 to 90. Over half of the plans reported between 1 and 10 appeals per 1,000 beneficiaries. A number of HMOs reported no appeals for each study year: 17 percent in 1996, 13 percent in 1997, and 9 percent in 1998. Nearly all of these HMOs (87 percent) had low Medicare enrollment. There was no similar pattern for plans with the highest appeal rates; they were spread nearly evenly across all plan sizes.[19]

The appeal rate may be rising. Plans reported just over 8 appeals per 1,000 beneficiaries in 1996 and 1997, but annualized data from the first 5 months of 1998 indicated more than 10 appeals per 1,000 beneficiaries. Aggregate appeals data may indicate potential problems with a plan's appeals process, but additional information is needed to assess whether a plan adequately performs this function. A relatively low appeal rate may be the result of a plan's low denial rate or members who are unaware of their appeal rights. Conversely, a plan that denies many requests or that actively educates members about their rights may experience a relatively high appeal rate. Consequently, appeals data should be considered in conjunction with other factors, such as the rates at which CHDR overturns plans' appeal decisions and HCFA's observations of plans' appeals process.

Some Beneficiaries May Disenroll Instead of Filing Appeals

The number of appeals may understate beneficiaries' dissatisfaction with their HMO's initial decision if some disenroll instead of appealing. Currently, beneficiaries may disenroll and switch to another plan or Medicare fee-for-service at the end of any month. As we have previously reported, many Medicare HMOs experience high disenrollment rates.[20] The extent to which beneficiaries choose to disenroll rather than appeal is unknown. It is clear, however, that disenrollees report less satisfaction with the care they received from their HMOs than enrollees. According to a survey conducted by HHS' OIG, disenrollees were much more likely than enrollees to say that their primary HMO doctor failed to provide Medicare-covered services.[21] The survey showed that 12 percent of the

[19]We divided the plans into four equal groups based on the Medicare beneficiary enrollment in each year data were reported. For example, for 1998 data, the quartiles were (1) 7 to 2,357 members; (2) 2,358 to 8,135 members; (3) 8,136 to 21,200 members; and (4) 21,201 to 250,366 members.

[20]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, Apr. 30, 1998) and Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996). Although some disenrollment is likely caused by beneficiaries' concerns over the care they received or their plans' unwillingness to provide requested services, other factors, such as the benefit packages offered by competing HMOs, likely play a role. GAO's data were unable to identify beneficiaries' reasons for disenrolling.

[21]HHS OIG, Beneficiary Perspectives of Medicare Risk HMOs, 1996 (OEI-06-95-00430, Mar. 1998).

disenrollees said that their doctors failed to provide covered services, whereas, only 3 percent of enrollees made such an assertion.

If some beneficiaries leave their plans instead of appealing adverse decisions, the number of appeals may rise as BBA's lock-in provisions take effect. Beginning January 1, 2002, beneficiaries will generally be able to change their enrollment decision only once each year outside the annual open enrollment period.[22] In 2002, this change must occur within the first 6 months of the year. In subsequent years, the change must occur within the first 3 months. After the disenrollment period ends (3 or 6 months), beneficiaries will be locked into their selected plans for the remainder of the year.

HHS' Inspector General and Advocacy Groups Find Beneficiaries Are Confused About Medicare Appeals Process

Studies by HHS' OIG and by the Medical Rights Center (MRC)[23] confirm the views of several advocacy group representatives that beneficiaries are confused about the Medicare appeals process.[24] HHS' OIG reported in March 1998 that 27 percent of Medicare HMO enrollees and 35 percent of disenrollees surveyed were uninformed about their appeal rights[25]—rates similar to those found by the Inspector General in 1993.

The results of an analysis conducted by MRC are consistent with the OIG's findings. MRC reported that 40 percent of the 179 beneficiaries who called the center between August 27, 1997, and February 28, 1998, were confused about their appeal rights. According to MRC officials, HMO physicians and customer service staff sometimes compounded beneficiaries' confusion. For example, MRC handled several cases where HMO customer service representatives allegedly gave out misleading, incorrect, or no information on beneficiaries' Medicare appeal rights. Representatives of other advocacy groups reported similar experiences and said that they believe many beneficiaries have difficulty understanding the appeals process.

[22]Exceptions are allowed for certain circumstances. For example, individuals who, upon becoming eligible for part A at age 65, enroll in a Medicare+Choice plan may switch to a different plan or fee-for-service at any time during the 12-month period beginning on the effective date of enrollment.

[23]MRC is a national not-for-profit organization that aims to ensure that Medicare beneficiaries have access to quality, affordable health care.

[24]The advocacy groups are the American Association of Retired Persons; Center for Medicare Advocacy, Connecticut; Center for Health Care Rights, Los Angeles; and Legal Assistance to the Elderly, San Francisco.

[25]HHS OIG, Beneficiary Perspectives of Medicare Risk HMOs, 1996. The Inspector General selected a random sample that included enrollees who were enrolled as of June 1996 and disenrollees who had disenrolled between March 1996 and June 1996 for reasons other than death.

Denial Notices Are Sometimes Incomplete or Never Issued

Beneficiaries are supposed to be informed of their appeal rights when they receive a written notice from their plan denying a service or payment.[26] These notices are required to state that the beneficiary has the right to appeal if he or she believes the plan's initial determination is incorrect. The notices must also tell the beneficiary where and when the appeal must be filed. However, HCFA, OIG, and our own analysis of CHDR appeal cases found numerous instances of incomplete or missing denial notices.

HCFA monitoring reviews indicate that some denial notices were not issued and others failed to mention beneficiaries' appeal rights. In 1997, HCFA performed 90 monitoring visits to health plans. About 13 percent of the plans reviewed were cited for failing to issue denial notices. Nearly one-quarter of the 90 plans were cited for issuing denial notices that did not adequately explain beneficiaries' appeal rights. Two studies by HHS' OIG provide additional evidence that beneficiaries are not always informed of their appeal rights. In one study, the OIG found that in 39 out of 144 appeal cases there was no evidence that the beneficiaries had been sent the plans' initial decisions explaining their appeal rights.[27] In another study, the OIG surveyed beneficiaries who were enrolled or had recently disenrolled from a managed care plan.[28] According to the results of a survey, 41 respondents (about 10 percent) said that their health plan had denied requested services. Of these, 34 (83 percent) said that they had not received the required notice explaining the denial and their appeal rights.

Similar deficiencies were found in the appeal cases reviewed at CHDR. Of the 108 CHDR appeal cases reviewed,[29] 5 contained denial notices that failed to inform the beneficiary of his or her appeal rights. Another 32 cases sent to CHDR by the plans lacked the denial notices completely.

[26]In addition, plans are required to explain members' appeal rights in the marketing materials they distribute.

[27]HHS OIG, Medicare HMO Appeal and Grievance Processes, Review of Cases (OEI-07-94-00283, Dec. 1996).

[28]HHS OIG, Medicare HMO Appeal and Grievance Processes, Beneficiaries' Understanding (OEI-07-96-00281, Dec. 1996).

[29]We selected these cases from completed decisions at CHDR during the month of October 1998. We randomly selected 27 cases from four case types: (1) expedited decisions upheld by CHDR (459 cases), (2) expedited decisions overturned by CHDR (159 cases), (3) nonexpedited decisions upheld by CHDR (1,772 cases), and (4) nonexpedited decisions overturned by CHDR (500 cases).

Some Notices Do Not Indicate Specific Reasons for the Denial

HCFA requires that denial notices clearly state the specific basis for denial. HCFA officials said that vaguely worded denial notices hinder enrollees' efforts to construct compelling counterarguments for their appeals. Also, vague notices may hinder beneficiaries from appealing because they may be uncertain as to whether they are entitled to the requested services.

Most notices we reviewed contained general, rather than specific, reasons for the denial. In 53 of the 74 CHDR cases that contained the required denial notices, the notices simply said that the beneficiary did not meet the coverage requirements or contained some other generic reason. It is unclear whether beneficiaries who receive denial notices with nonspecific reasons are less likely to submit written support for their position compared to beneficiaries who receive more detailed notices. Beneficiaries had submitted written support in only 14 of the CHDR appeal cases.[30]

Reconsideration notices written by CHDR personnel provide much greater detail than notices written by plan personnel. For example, in one case, the health plan issued a notice of noncoverage for skilled nursing facility (SNF) services, stating

> you required skilled rehabilitation services—P.T. eval. for mobility + gait—eval. for ADL's, speech eval. swallowing—from 2/11/98 and these services are no longer needed on a daily basis.[31]

CHDR's letter to the beneficiary (upholding the HMO's denial) stated the following:

> The case file indicated that while [name] was making progress in his therapy programs, his condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that he reached his maximum potential in therapy. He had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that his speech was much improved by 2/18/98 and that his private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.

Representatives from several advocacy groups told us that in cases brought to their attention, the denial notices were often general and did

[30]In one case, it was impossible to determine whether the beneficiary had submitted a written argument.

[31]"P.T." stands for physical therapy, "eval." stands for evaluation, and "ADL' stands for activities of daily living.

not clearly explain why the beneficiary would not receive or continue to receive a specific service. In August 1997, MRC established a hotline for HMO appeals and analyzed all calls it received during the first 6-month period (179).[32] MRC concluded that the explanations found in most plans' denial notices were unhelpful because of their generality—for example, the services were "not medically necessary."[33]

Notices of Discontinued Coverage Are Often Issued 1 Day Before Services Are Stopped

HCFA regulations state that whenever plans discontinue services, they must issue timely denial notices to beneficiaries. HCFA, however, does not specify how much advance notice is required and we found that many plans do not issue denial notices in what many would reasonably consider "timely." Although beneficiaries may appeal denied services upon receiving notice, those who receive little advance notice may not be able to continue to receive services because of their potential financial liability. If the beneficiary appeals and loses, he or she is responsible for the cost associated with services received after the date specified in the denial notice. The potential financial burden can be substantial, especially if the denial involves SNF services.

In three of the four plans we visited, the general practice was to issue denial notices the day before services were discontinued. We reviewed a number of SNF discharge notices at three HMOs and often found that the notices were mailed (usually by certified or express mail) to the beneficiary's home instead of being delivered to the facility where the beneficiary resided. In some cases, it appeared that the beneficiary or his or her representative received the notice a few days after the beneficiary had been discharged. Ten of the 25 CHDR cases we reviewed also involved a beneficiary or his or her representative receiving a discharge notice after the beneficiary was discharged from the SNF.[34]

The fourth plan we visited issued SNF discharge notices 3 days prior to the discharge date. This lead time helped ensure that the beneficiary received the notice before the discharge. It also allowed more time for the beneficiary to file an expedited appeal and receive a decision from the plan. Consequently, beneficiaries in this plan who appeal and lose are less exposed to SNF costs incurred during the appeals process.

[32]The hotline operated for 2 hours a day, 4 days a week. At other times, a caller was instructed to leave a message or seek assistance from another organization listed on their denial notice.

[33]MRC, Systemic Problems With Medicare HMOs: Case Studies From the Medicare Rights Center HMO Hotline (Sept. 1998).

[34]There were 27 cases involving SNF discharges, but 2 cases had conflicting data.

Officials in three plans indicated that when a beneficiary is being considered for discharge, a nurse or discharge planner probably would have discussed the issue with the beneficiary well in advance of the discharge. Even when a beneficiary knows a discharge is imminent, however, he or she cannot appeal until a denial notice is officially issued. Officials from the plans we visited told us that, in almost every instance, the decision to discharge a beneficiary from a SNF is made several days before the actual discharge date. Officials from all the plans agreed that, in most instances, such notices could be issued several days prior to the discharge date so that beneficiaries who wished to appeal could receive an expedited appeal decision before the planned discharge date.

HCFA's Oversight of Plans' Appeals Procedures Is Limited

HCFA's biennial monitoring of plans' appeals process focuses on timeliness and administrative issues, but we found several important weaknesses in the agency's monitoring procedures. For example, HCFA's sampling of cases to determine whether beneficiaries are appropriately informed of their appeal rights likely misses beneficiaries who were not informed. HCFA's monitoring also generally excludes the operations of HMO provider groups that may be responsible for making denial decisions and for issuing the required notices. HCFA officials believe that the agency can improve in many of these areas, and in commenting on a draft of this report, HCFA said that it has begun to address these weaknesses. However, to date, HCFA has made little use of the results of its HMO performance reviews to develop overall national trends and improve the agency's oversight function.

HCFA's Monitoring Protocol Systematically Misses Beneficiaries Who May Not Have Been Informed of Their Appeal Rights

To determine whether plans informed beneficiaries of their appeal rights, HCFA's monitoring protocol requires agency staff to review a sample of appeal cases. HCFA staff check these case files to determine whether each contains a copy of the required denial notice. However, it seems reasonable to assume that beneficiaries who appeal denials are more likely to have been informed of their rights than beneficiaries who do not appeal. Yet HCFA does not check cases where services or payment for services were denied and not appealed. HCFA might get a better indication of whether beneficiaries were told of their rights if agency staff examined a sample of denial notices from cases that were not appealed.

HCFA and Plans Exercise Little Oversight of Administrative Tasks Delegated to Provider Groups

Some health plans delegate the responsibility for deciding whether to expedite initial decisions, issuing denial notices, and other operating tasks to medical provider groups. For example, one plan we visited had delegated the responsibility of issuing service and payment denial notices, including paying claims, to approximately 250 provider groups with which it contracted. A plan official stated that his plan has never reviewed service denials and does not know how many services its provider groups have denied. The plan has, however, recently developed a monitoring protocol to review service denials and intends to implement it soon. According to several HMO officials, this practice is common in California and is increasing in other parts of the country.

Officials also said that HMOs typically exercise little or no oversight over provider groups' operations and have difficulty ensuring that groups adequately perform the delegated tasks. For example, according to an official from another HMO, provider groups on the West Coast expect plans to grant them the authority to issue denial notices because they are at financial risk for the services they provide. To contract with these groups, his plan must delegate that authority even though the practice is not desirable from his HMO's perspective. He said that provider groups often do not send the plans copies of issued denial notices, although the plans request them. The official estimated that his plan receives only about 30 percent of the denial notices issued by their provider groups. He added that his plan does not review the notices it does receive.

Moreover, according to a HCFA official, HCFA does not generally monitor HMO provider groups. Because provider groups may not submit requested information to HMOs and HCFA does not normally monitor provider groups directly, it is likely that no one reviews many of the initial decisions—including expedited decisions—made by these groups. A 1998 study done for HCFA noted that the delegation of authority to provider groups is problematic because health plans do not exercise sufficient control over the delegated functions.[35] The report recommended that HCFA pay closer attention to this issue.

HCFA Has Provided Limited Guidance to Plans on Expedited Appeals Process

Although HCFA has provided plans with general guidance, such as model language for denial notices, it has not produced specific guidelines to ensure consistent implementation of the expedited appeals process. Further, without clear guidelines on what should be expedited, HCFA has

[35]Bailit Health Purchasing, LLC, The Medicare Managed Care Compliance Monitoring Program: Recommendations for Modification and Improvement (Jan. 28, 1998).

no way of determining whether plans are expediting initial decisions and appeals appropriately. HCFA has not produced criteria or examples for HMOs to follow when deciding whether the standard appeal time frames could seriously jeopardize a beneficiary's health or life. In the absence of such criteria, Medicare HMOs have a wide latitude to determine whether a beneficiary's request for an initial decision or appeal should be expedited.

Receiving no specific guidance from HCFA, several California HMO and provider industry representatives formed a work group and developed clinical criteria for expedited initial decisions and appeals. In January 1998, the HCFA region responsible for Arizona, California, and Nevada provided the work group's criteria to all Medicare HMOs in those three states. HCFA officials said they are not aware of similar efforts in other regions. We found, however, that at least one Florida HMO had incorporated much of the California work group's criteria into its own procedures—possibly because the HMO also operated in California.

Without better guidance from HCFA, some cases that should be expedited may not be. In our review of cases sent to CHDR, we examined 42 appeals involving denied services that HMOs had not expedited. CHDR reviewers determined that seven (17 percent) of these cases should have been expedited. (CHDR expedited these cases for its own review process.)

HCFA Makes Little Use of Available Data for National Program Management

Staff from HCFA's central and regional offices told us that the agency has made little use of its monitoring reports as an overall program management tool. Each report documents the results of HCFA's biennial performance review of a plan and summarizes its compliance with Medicare regulations. Aggregating the findings from the individual monitoring reports could help HCFA monitor the relative performance of plans, identify variations among regions, and study national trends. However, when we requested all of the 1997 monitoring reports no one at HCFA's headquarters had a complete set. We were told that we would have to request them from each region.

Shortly after we requested the reports from the regions, the Health Plan Purchasing and Administration Group in HCFA's central office began collecting from the regional offices all 1996 and 1997 monitoring reports. According to HCFA officials, agency staff are now analyzing the information in the reports.

HCFA is planning to develop a health plan management system that will provide information to central and regional office staff and will aid plan and program oversight. The system will include information on appeals. HCFA had expected to complete the data design phase by now but has fallen behind schedule. According to the project manager, the system will not be operational until late 1999 or early 2000.

HCFA Has Not Required Plans to Collect and Report Data on Appeals

The need for both HCFA and Medicare beneficiaries to have information on HMO appeals is well recognized. In 1996, and again in 1998, HHS' OIG recommended that HCFA require managed care plans to report data on appeals, such as the number of cases, the number resolved internally and externally, issues involved, and the time needed to resolve cases.[36] Also, in implementing its expedited process, HCFA is requiring plans to report data on expedited appeals. Further, BBA requires plans to disclose information on the number and the disposition of appeals to interested Medicare beneficiaries.

On February 10, 1999, HCFA issued an operational policy letter that establishes the guidance for managed care plans to follow in collecting appeals data and making that information available to Medicare beneficiaries. Plans will report the number of appeals per 1,000 Medicare beneficiaries. Each plan's rate will be based on its contract market.[37] Plans will begin collecting and maintaining appeals data beginning April 1, 1999. Data collection periods will be based on a rolling 12-month period. (The prior 6 months of data are added to the next 6 months of data in order to come up with a 12-month data collection period.) The first 6-month period will begin April 1, 1999, and end September 30, 1999. Plans will report results from the first 6-month period on January 1, 2000.

HCFA, however, has not provided guidance on the type of appeals data plans should collect and report to HCFA. According to officials in HCFA's central office, the agency has formed a work group—consisting of plan representatives, advocacy representatives, and program officials—to develop appeals data requirements. HCFA expects to finalize these requirements later this year. Meanwhile, some HMOs may be waiting to receive HCFA's guidelines before they implement systems to track their appeals data. Although all the plans that responded to our survey reported

[36]HHS OIG, Medicare HMO Appeal and Grievance Process: Overview (OEI-07-94-00280, Dec. 1996), and Medicare's Oversight of Managed Care: Monitoring Plan Performance (OEI-01-96-00190, Apr. 1998).

[37]Contract market implies either reporting by contract or by a market area within a contract. This determination will be made by HCFA.

the total number of appeals upheld and overturned, only about two-thirds were able to break down their appeals into more specific service categories, such as nursing home care and emergency room use.

Conclusions

Medicare beneficiaries have access to a multilevel appeals process that allows them to challenge HMO decisions to deny services or payment for services. Relatively few beneficiaries—about 9 out of every 1,000 managed care enrollees—appeal each year. Some beneficiaries may not appeal, however, because they are unaware of their appeal rights or confused about the process. Evidence from a variety of sources—HCFA monitoring reports, studies by HHS' OIG, and our review of cases at plans and at CHDR—indicate that plans do not always inform beneficiaries of their appeal rights as required. In some cases, denial notices cite nonspecific reasons for the denial, making it more difficult for beneficiaries to challenge their plan's decision. In other cases, beneficiaries may be unnecessarily exposed to substantial health care costs because notices are not issued in a timely fashion. Furthermore, the agency has not issued specific guidance as to the types of cases plans should expedite.

HCFA reviews plans' implementation of the appeals process, but its monitoring protocol exhibits several weaknesses. For example, HCFA does not know whether provider groups have satisfactorily implemented the required appeals process because it exercises little oversight over provider group operations. The type of cases HCFA samples to determine whether beneficiaries were informed of their appeal rights likely systematically misses beneficiaries who were not informed. Further, the agency has not provided plans guidance on the types of appeals data they should collect and report to HCFA. HCFA agrees that it needs to strengthen its oversight of health plans' appeals process and noted that the agency has several initiatives under way.

Recommendations

To help ensure that the appeals process provides adequate protection to Medicare beneficiaries, the HCFA Administrator should take the following actions:

- Provide more explicit denial notice instructions to plans. Denial notices should explain the coverage criteria and state the specific reason or reasons why the beneficiary did not meet the criteria.

- Set specific timeliness standards for certain types of denial notices, such as discontinued SNF care services, to allow beneficiaries reasonable time to obtain an expedited appeal decision.
- Develop criteria for plans to use in determining when initial decisions and appeals should be expedited.

To improve the agency's monitoring of the appeals process, the HCFA Administrator should take the following actions:

- Require each plan to collect sufficient information from its provider groups so that HCFA staff can, during the course of a normal biennial performance review, determine whether the plan and its provider groups satisfactorily implemented the required appeals process.
- Require agency staff conducting performance reviews to sample a number of denied cases that were not appealed to determine whether beneficiaries were informed of their appeal rights.
- Use the data the agency collects during plan performance reviews to assess the relative performance of plans, and develop strategies for better plan monitoring and program management.

To ensure that appeals data are available to HCFA and Medicare beneficiaries, the Administrator should develop requirements for the type and format of appeals data plans must collect and make available.

Agency Comments and Our Evaluation

HCFA agreed with our finding that its oversight of health plans' appeals process needs to be strengthened and generally agreed with our recommendations. (See app. II for HCFA's written comments regarding our recommendations.) The agency outlined several initiatives it has recently undertaken to better protect beneficiary rights. Some of these initiatives may be implemented shortly; others are in the early planning stage.

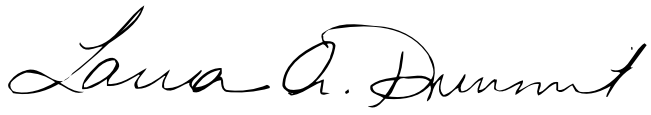
HCFA expressed concern, however, about our recommendation that the agency develop criteria to help plans determine when initial and appeal decisions should be expedited. HCFA said that a further refinement of the current general criteria might inadvertently exclude unspecified standards. HCFA said that it would explore possible options regarding the criteria, but that it would proceed cautiously to avoid unanticipated problems. We disagree with the premise that further refinement of the criteria would inadvertently limit beneficiary access to expedited initial and appeal decisions. As noted in this report, specific clinical criteria have been developed and used by plans in at least one HCFA region. HCFA could

develop specific criteria, to be implemented nationwide, that are understood to be an elaboration of the current general criteria and not a replacement for them.

In addition, HCFA provided several technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents earlier, we plan no further distribution of this report until 1 day from the date of this letter. At that time, we will send copies to the Honorable Donna Shalala, Secretary of HHS; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; and interested congressional committees and members. We will also make copies available to others on request.

Please contact me at (202) 512-7119 or James Cosgrove, Assistant Director, at (202) 512-7029 if you or your staff have any further questions. This report was prepared by Cam Zola, Richard Neuman, and Beverly Ross.



Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Contents

Abbreviations

ALJ	administrative law judge
BBA	Balanced Budget Act of 1997
CHDR	Center for Health Dispute Resolution
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MRC	Medical Rights Center
OIG	Office of Inspector General
SNF	skilled nursing facility

Scope and Methodology

To obtain information on plan-level appeals handled by HMOs during 1996, 1997, and the first 5 months of 1998, we surveyed all (307) Medicare HMOs that were active as of May 31, 1998. We obtained responses from 250 plans (81.4 percent).

We visited three judgmentally selected HMOs—one in California and two in Florida. We selected these plans based on (1) geographic location, (2) high 1997 disenrollment rates, and (3) high Medicare enrollments. Our visit to one Florida HMO coincided with a monitoring visit by HCFA's region IV staff. During our visits, we discussed the appeals process with plan officials and reviewed a limited number of cases at three of the locations. The cases included standard appeals and expedited appeals that were upheld and overturned at the plan level within the 6 months prior to our visit. Each case reviewed was discussed with a plan official responsible for the plan's appeals process. In addition, we made a site visit to an HMO in Maryland during a HCFA monitoring visit. Our visit to the Maryland HMO was limited to overseeing the monitoring team's review of appeal cases and several discussions with plan officials.

We visited the two HCFA regional offices (region IX in San Francisco, California, and region IV in Atlanta, Georgia) responsible for the three plans we visited. We discussed the appeals process and the monitoring effort with appropriate officials in each region. We also spoke with regional personnel in HCFA's region X about the appeals process and HCFA's monitoring effort and results. In addition, we obtained from HCFA a summary spreadsheet that showed all the monitoring reports completed in 1997 and summarized plan compliance with Medicare requirements. From this list, we selected and reviewed the monitoring reports of plans that indicated deficiencies in the categories related to the appeals process, denial notices, or both.

With assistance from CHDR we randomly selected and reviewed 108 appeal cases that had been adjudicated by CHDR in 1998 and had not been sent to storage as of October 1998. We developed a data collection instrument and specific criteria for evaluating the case file information. A CHDR analyst, who reviewed each case and recorded the review results, used this instrument and criteria. We reviewed the results of over half of the 108 cases to ensure the data were recorded accurately and met our evaluation criteria.

We discussed HCFA's appeal policy and practice with HCFA officials and representatives from five advocacy groups representing Medicare

beneficiaries in health plans. In addition, we reviewed a number of HHS OIG reports covering several aspects of Medicare's appeals process in HMOs. Also, we reviewed a report done by the Medicare Rights Center that discussed systemwide problems with Medicare HMOs.

Our office of General Counsel reviewed the results of a class action lawsuit and the resulting appeal by HCFA before the 9th U.S. Circuit Court of Appeals.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 12, 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare Managed Care: Greater Oversight Needed to Protect Beneficiaries' Rights"

TO: William J. Scanlon, Director
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress concerning the Medicare managed care appeals process. We agree with the report's findings that HCFA's oversight of health plans' appeals processes needs to be greatly strengthened, and we are currently undertaking several initiatives in that regard to better serve our Medicare beneficiaries.

In general, we agree with the recommendations the GAO has made in the report, and are enclosing our comments to the specific recommendations. We look forward to working with GAO and the Congress as we continue to ensure that beneficiaries are provided with ample information on both appeal and disenrollment rights.

Enclosure

Comment of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, "Medicare Managed Care: Greater Oversight Needed to Protect Beneficiaries' Rights"

General Comments

HCFA has undertaken a number of initiatives to better protect Medicare beneficiaries' rights. The agency has established various vehicles to ensure that beneficiaries are provided with ample information on both appeal and disenrollment rights. Under HCFA's direction, plans annually create member materials to inform beneficiaries of their appeal rights (these member materials include but are not limited to member handbooks, evidence of coverage notices, and denial notices). These materials must be written in a culturally competent manner that is understandable to the beneficiary, and Medicare+Choice (M+C) organizations must obtain HCFA approval before dissemination.

HCFA is also piloting a disenrollment process at the Medicare Choices Helpline, 1-800-Medicar[e]. The pilot project will establish an alternative neutral mechanism enabling a beneficiary to disenroll from a managed care plan and revert to original Medicare fee for service without going to the Social Security Administration (SSA). As part of the pilot a tool will be devloped (the new HCFA R-257 disenrollment form) to capture useful disenrollment reason information from beneficiaries.

Additionally, HCFA is currently administering a disenrollment survey under the Medicare Consumer Assessment of Health Plan Study (CAHPS). The purpose of this survey is to obtain reasons why beneficiaries are disenrolling. This survey will be implemented nation-wide in the Fall of 1999, and it will provide HCFA with a cross section of nation-wide information while tracking ongoing disenrollment information.

HCFA has consulted with consumer groups and representatives of managed care plans to help determine the types of grievance and appeal measures that are valid, reasonable, and helpful to prospective enrollees. In the Fall of 1998, HCFA formed an Appeal/Grievance/ Complaint Workgroup to recommend the appeal and grievance data that M+C organizations should make available to beneficiaries.

GAO Recommendation #1

To help ensure that the appeal process provides adequate protection to Medicare beneficiaries, the HCFA Administrator should take the following actions:

-- Provide more explicit denial notice instructions to plans. Denial notices should explain the coverage criteria and state the specific reason(s) why the beneficiary did not meet criteria.

HCFA Comment

HCFA concurs with the recommendation. In fact, HCFA has been planning to publish an operational policy letter (OPL) in early 1999 instructing M+C organizations that they must be explicit in their denial notices to beneficiaries. Plans should notify beneficiaries of any adverse coverage determination in writing and include a detailed explanation of the coverage criteria within the body of the notice. Model language for denial notices has been provided to M+C organizations and delegated providers. Portions of this model denial language may be used in other member materials as well.

GAO Recommendation #2

-- Set specific timeliness standards for certain types of denial notices, such as, discontinued skilled nursing facility (SNF) care services, to allow beneficiaries reasonable time to obtain an expedited appeal decision.

HCFA Comment

HCFA agrees that timeliness standards should be set for certain types of denial notices and that enrollees should receive such notices prior to discharge. HCFA has been exploring the need to establish timeliness standards for notices -- other than adverse organization determinations and inpatient hospital discharges for which there are already specific requirements. In particular, we have commenced a regulation team to develop a notice of proposed rulemaking (NPRM) addressing when M+C organizations should issue notice to beneficiaries in the case of service reductions or discontinuations (such as SNF care, home health, or physical therapy). Further, we have committed to work with members of the beneficiary advocacy community and industry representatives to obtain guidance on how best to operationalize any new requirement.

GAO Recommendation #3

-- Develop criteria for plans to use in determining when initial decisions and appeals should be expedited.

HCFA Comment

Under § 1852(g)(3)(B)(ii) of the Social Security Act, M+C organizations are required to expedite any request for a service "if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." The preamble to the April 30, 1997, Expedited Review final rule with comment that applies to grandfathered 1876 cost contracts provides that requests for reconsideration of noncoverage determinations for inpatient stays, other than hospital discharges for which immediate Peer Review Organization review is available, will be expedited. It also provides that requests for reconsiderations of determinations to discontinue a service (such as physical therapy) in the home or outpatient setting where a longer review time could jeopardize the enrollee's life, health, or ability to regain his or her maximum function, will be expedited.

HCFA has a concern that a further refinement of the criteria would inadvertently exclude unspecified standards. As a result,we are proceeding cautiously so as to avoid any unanticipated problems. HCFA will explore possible options regarding criteria that could be used for granting expedited requests for services.

GAO Recommendation #4

-- Require each plan to collect sufficient information from its provider groups so that HCFA staff can, during the course of a normal biennial performance review, determine whether the plan and its provider groups satisfactorily implemented the required appeals process.

HCFA Comment

HCFA concurs with the recommendation. HCFA is implementing parts of the Part C regulation though the Quality Improvement System for Managed Care (QISMC).

Under this system, HCFA specifies the requirements for M+C organizations who elect to delegate functions to outside entities. These include making the M+C organization accountable for any function delegated to an outside organization. The requirements also call for written delegation agreements; pre-evaluation of the delegated entity's ability to

perform the delegated function, and monitoring. HCFA expects to complete revisions to its monitoring protocol, the Contractor Performance Monitoring System, in late Spring 1999. This protocol should include the Part C requirements. The Contractor Performance Monitoring System will also contain a new QISMC section.

HCFA also conducts sampling in order to determine compliance with some of the requirements for the appeals process. Samples are random and may, or may not, include files of beneficiaries who are receiving their appeals rights from a delegated provider group. Under HCFA's current policy, the M+C organization is responsible for the appeals function regardless of any delegated function. HCFA will focus its attention on ensuring that M+C organizations understand the delegation requirements as outlined in QISMC and that M+C organizations understand their continued accountability. HCFA will also review evaluation methods to provider groups when appropriate.

Regulations implementing the Balanced Budget Act of 1997 (BBA) gave HCFA additional authorities to enforce the managed care appeals process. The Part C regulation at 42 CFR 422.510(a) allows HCFA to initiate enforcement actions against an M+C organization that "substantially fails to comply" with the appeals and grievances requirements in subpart M. These enforcement actions include termination, nonrenewal of the M+C contract, and intermediate sanctions.

GAO Recommendation #5

-- Require agency staff conducting performance reviews to sample a number of denied cases that were not appealed to determine whether beneficiaries were informed of their appeal rights.

HCFA Comment

HCFA concurs with the recommendation. Regional office staff currently review a sample of an M+C organization's claims denials as part of the Claims Processing review. HCFA staff must make a determination on HCFA's Review of Denied Claims worksheet (Form WS-CP2) as to whether a claims denial was proper and whether the correct appeals language was provided in the denial notice.

HCFA is currently updating the monitoring guide to incorporate the Part C requirements. HCFA intends to include a reference to the Medicare Organization Determinations and Appeals section in the Claims Processing Section, and on the Review of Denied Claims worksheet.

GAO Recommendation #6

-- Utilize the data the agency collects during plan performance reviews to assess the relative performance of plans and develop strategies for better plan monitoring and program management.

HCFA Comment

HCFA concurs with the recommendation. HCFA is embarking on an effort to analyze the data from the M+C organization monitoring database and has recently completed collection and validation of the FY 1998 data. Data collected from FY 1997 and FY 1998 is currently being analyzed to determine commonalities and trends that exist among the data collection periods at all levels: national, regional, market and M+C organization. Results from this data analysis will be used by the HCFA managers to more effectively focus agency monitoring efforts by providing relevant and timely information to their staff. In addition, results from this data analysis may be used by HCFA to inform M+C organizations of industry-wide areas of improvement.

As a long term project, HCFA will be developing strategies to enhance the uses of M+C organization data collected through the current M+C organization monitoring process as well as utilizing several additional relevant M+C organization data, such as CAHPS, and the Medicare Health Outcomes Survey. HCFA plans to analyze the different data sources and use this information to make changes in its overall M+C organization monitoring strategy, including the development of M+C organization performance measures.

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