
August 1995

MEDICARE

Increased HMO Oversight Could Improve Quality and Access to Care





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

B-259299

August 3, 1995

The Honorable David H. Pryor
Ranking Minority Member
The Honorable William S. Cohen
Chairman
Special Committee on Aging
United States Senate

The Congress is considering ways to attract Medicare beneficiaries to health maintenance organizations (HMO) and other forms of managed care in hopes of containing cost growth while preserving or improving quality and access to care. HMOs are currently the only widely available form of managed care in Medicare, and about 7 percent of beneficiaries have joined prepaid, "risk contract" HMOs.¹ In contrast, HMOs enroll 25 percent of the employed population. Recent growth of HMO enrollment in both Medicare and employed populations has been rapid. The number of Medicare HMO risk contracts increased 70 percent, to 154, in the 2 years preceding January 1995.

HMOs offer the potential to coordinate all the services needed to treat a patient while controlling for overuse of costly services. The incentive for HMOs to control utilization comes from the payment method in which HMOs are paid a fixed amount per beneficiary for providing health care services. HMOs bear the financial risk for ensuring that their costs do not exceed their fixed payments.

This report responds to your request that we review federal oversight of HMOs that enroll Medicare beneficiaries. Specifically, this letter responds to your interest in (1) the Health Care Financing Administration's (HCFA) monitoring of HMOs' compliance with federal quality assurance standards, (2) HCFA's enforcement actions against HMOs that do not meet federal standards, (3) the effectiveness of the process available to beneficiaries to appeal an HMO's decision to deny care, and (4) approaches the private sector is taking to assure HMO beneficiaries of quality care. HCFA is delegated this oversight responsibility by the Secretary of Health and Human Services.

¹Our use of the term "Medicare HMOs" in this report includes both HMOs and Competitive Medical Plans holding Medicare risk contracts for prepaid care. Competitive Medical Plans are subject to regulatory requirements similar to those for HMOs, but they have more flexibility in how they set premiums and services for commercial members.

To do our work, we reviewed federal HMO oversight standards, practices, and compliance issues with HCFA officials at headquarters and three regional offices. We also reviewed three enforcement cases that were in process as of June 1994. In addition, we met with representatives of the National Committee for Quality Assurance; the Group Health Association of America; and the consumer advocacy group, Center for Health Care Rights. (See app. II for details on our scope and methodology.)

Results in Brief

Although HCFA has instituted several promising improvements, its process for monitoring and enforcing Medicare HMO performance standards continues to suffer from three significant limitations:

- Quality assurance reviews are not comprehensive. Even HMOs with many serious documented quality problems were not found to be out of compliance with requirements by HCFA's routine monitoring. HCFA routinely only reviews the HMO's description of its quality assurance processes—it does not check to see whether HMOs implement these processes effectively. HCFA also does not adequately assess the financial risk arrangements that HMOs have with providers, although these arrangements can create incentives to underserve beneficiaries.
- Enforcement actions are weak. When HCFA has documented problems in HMOs that have been slow to correct deficiencies, it has been reluctant to use sanctions and other enforcement tools at its disposal. Under HCFA's enforcement approach, serious improprieties by a few Medicare HMOs—subjecting beneficiaries to abusive sales practices, unduly delaying their appeals, or exhibiting patterns of poor quality care—have taken years to resolve.
- Appeal process is slow. Beneficiaries who appeal HMO denials often wait 6 months or more for resolution. The consequences for beneficiaries can be prolonged uncertainty, high out-of-pocket costs, and having to disenroll from an HMO to obtain services.

Increasingly, sponsors of employee health plans are requiring that HMOs undergo accreditation reviews to obtain contracts with their plans. Moreover, the leading HMO accreditation agency publicizes results of its reviews. Some large employers also require information about the care provided to gauge an HMO's overall performance when making contract decisions. HCFA's current regulatory approach to ensuring good HMO performance lags behind these latest private sector practices.

Background

HMOs are expected to provide all covered services to members in return for fixed premiums. HMOs may have their own staff of physicians and other providers to deliver care, or they may contract with individual providers or medical groups to deliver services. From the Medicare beneficiaries' perspective, HMOs may offer a more comprehensive package of services than fee-for-service Medicare and at a lower cost than beneficiaries might incur if they purchased such coverage through supplementary insurance.

HMOs were designed to offer preventive health services inexpensively and to constrain the provision of expensive services, primarily through the use of a reimbursement method known as capitation. Under capitation, Medicare pays HMOs a fixed amount per month for each beneficiary. This method typically places HMOs at risk for health costs, thereby giving them a financial incentive to control the use of services, emphasize preventative care, and avoid unnecessary care. Some HMOs, in turn, transfer a portion of their financial risk to care providers, such as physicians or physician groups.

Federal Government Sets Initial Standards for HMO Industry

To encourage commercial and Medicare use of HMOs, in the early 1970s, the Congress authorized federal standards and oversight to ensure reasonable care and service.² For example, initial legislation authorizing a Medicare HMO program required quality of care standards at least equal to those prevailing in the HMO's service area. In addition, HMOs had to have sufficient operating experience and enrollment to permit evaluation of their capacity to provide appropriate care, and to sustain financial losses if the Medicare payment did not cover costs.

Federal standards were strengthened as the government gained experience with HMOs. Currently, performance standards for HMOs serving Medicare beneficiaries are designed to safeguard beneficiary interests by ensuring the following:

- Plans have adequate finances and management. HMOs must meet financial solvency requirements, have minimum enrollments necessary to assume the financial risks, and provide adequate administration and management.
- Plans manage quality, utilization, and access to medical care. Plans must operate internal quality assurance systems to detect and correct patterns of underservice and poor quality care, provide reasonable access to

²Title 18 of the Social Security Act and title 13 of the Public Health Service Act impose requirements HMOs must meet in order to enter into contracts with Medicare and provide services to beneficiaries.

specialists and services, and not transfer excessive financial risk to providers.

- Plans treat enrollees fairly. HMOs must use fair marketing practices that do not mislead or confuse enrollees, must provide necessary and covered services, and must follow equitable grievance and appeal procedures.

Before an HMO may participate in Medicare, HCFA conducts a review to determine if the HMO meets federal requirements. During this “certification” review, HCFA looks at several indicators of the HMO’s ability to provide services to Medicare beneficiaries. These indicators include documentation of financial condition, marketing projections, qualifications of management staff, and management information systems. After awarding a Medicare contract to an HMO, HCFA monitors its performance for continued compliance with federal requirements. HCFA also contracts with peer review organizations (PRO)—independent, state-based organizations that use local doctors and nurses—to assess quality of care provided to beneficiaries.

HCFA has a variety of tools available to enforce compliance with standards. These include authority to sanction an HMO by terminating or not renewing its contract, stopping enrollment, or imposing monetary penalties. Additionally, HCFA has numerous administrative means to encourage compliance, such as withholding an HMO’s request for expanding service areas.

Private Sector Building on Federal Standards

HMO care has become widespread in the private sector. In seeking ways to ensure quality and value in HMO care, large employers and the HMO industry are demanding HMO accountability beyond existing federal protections. Some large employers, for example, are requiring that HMOs undergo quality accreditation reviews conducted by the National Committee for Quality Assurance (NCQA). NCQA is a private agency that works with large employers to set and enforce HMO quality standards. Its standards focus primarily on quality assurance in HMOs’ management of medical operations, and its review and enforcement methods differ from HCFA’s. In addition, a group of large employers and HMOs are working with NCQA to develop standard performance measures for HMOs that would enable employers and consumers to compare HMOs and make informed choices.

Difficulties in Federal Oversight Illustrated by Florida Case Study

Recent enforcement cases show that HCFA processes remain slow at addressing problems in HMOs that do not readily comply with federal standards. PRO sampling of care in Florida during 1991 raised concerns with the quality of care at one HMO. The HMO questioned these findings, leading to a special PRO review and to the events discussed below.

In 1992 and 1993 the PRO found serious quality problems in most of the risk contract HMOs in the Florida Medicare market, which has about 17 percent of all Medicare HMO enrollees. PRO review of hospitalized patients at one HMO, for example, raised serious issues about quality in 25 percent of the 109 cases sampled. After reviewing PRO findings, an internal HCFA task force suggested special investigations of quality assurance and utilization management practices at all Florida Medicare risk HMOs. PRO sampling of care in Florida Medicare HMOs, for example, found patterns of quality problems, including incorrect diagnoses, inappropriate assessment of test results, inappropriate treatment plans, underutilization, access concerns, delays in treatment, and treatment that was not competent or timely. Specific cases included the following:

- Delay in treatment. A beneficiary suffered recurrent urinary tract infections, tested positive for protein and blood in the urine, and had test results that suggested the presence of prostate cancer. Several months passed before the HMO referred him to a urologist and before the urologist performed further tests. The patient ended up in a hospital emergency room, and was treated for undiagnosed bladder cancer that had perforated the large intestine.
- Treatment not competent or timely. A beneficiary was treated with a blood-thinning drug that requires careful monitoring to avoid excessive bleeding. As a result of inadequate monitoring, the patient was admitted to a hospital with internal bleeding, which was found to be due to an excess of the blood-thinning drug.
- Denial of access. In a 24-hour period, a beneficiary with signs and symptoms of both pneumonia and a heart attack twice sought and was denied admission to a hospital. The HMO primary care physician concurred with both denials of admission. After the second attempt, the patient died on the way to his primary care physician.

HCFA's oversight of one of the Florida risk HMOs illustrates the pattern that has emerged between HCFA and HMOs that do not take prompt actions to correct performance problems. This HMO won a HCFA demonstration

contract in 1982.³ After a series of financial problems and other compliance violations, the HMO was declared insolvent in 1987, and another HMO acquired its assets.

The new HMO operates in four Florida markets under a single contract with HCFA. The HCFA enforcement activity documented in the following paragraphs relates to the South Florida market, but enrollment and payment statistics in table 1 relate to all four markets. HCFA data systems track the HMO's contract as though it were a single-market HMO—the normal contracting arrangement for Medicare.

Since 1987, HCFA repeatedly found that the HMO's South Florida operations did not meet federal standards for quality assurance. During this period, HCFA undertook special studies and received PRO reports that indicated continuing problems with quality of care. Nevertheless, it allowed the HMO to continue enrolling beneficiaries and operating as freely as a fully compliant HMO, until HCFA's 1994 investigation of quality assurance practices led to voluntary enrollment restrictions at selected medical centers. From 1988 to 1994, the HMO maintained and increased its revenues from Medicare by enrolling over 336,500 beneficiaries to replace the over 269,000 who disenrolled. The HMO had Medicare revenues in 1994 that exceeded \$1 billion and constituted 72 percent of its total revenues.

HCFA recently determined that the South Florida HMO has been responsive to its 1994 findings and in January 1995 approved the HMO's corrective action plan. HCFA has since visited the HMO's offices and declared the HMO in compliance with requirements, effective July 5, 1995. (Table 1 presents the history of HCFA's oversight and enforcement related to the HMO's quality assurance practices, including PRO reviews of quality of care.)

³In 1982 and 1983, HCFA awarded contracts under its demonstration authority to 26 organizations to develop Medicare HMOs. Such demonstration projects became operational in 21 cities across the country.

Table 1: An Example of an Ineffective Compliance Effort

| Time frame | Activity | New enrollment in year | Disenrollment in year | Medicare payments (millions) |
|-------------------|--|-------------------------------|------------------------------|-------------------------------------|
| 1987 | | | | |
| May | HCFA notifies Florida-based HMO of intent to terminate contract because of quality assurance deficiency. Inspector General asks PRO to review the HMO's care. | | | |
| June | PRO finds the HMO's care below professional standards. State declares the HMO insolvent, and another HMO buys its assets. PRO to review quality assurance (QA). | | | |
| 1988 | | 39,194 | 28,151 | \$398.9 |
| June | HCFA finds that the new HMO generally met QA requirements, while PRO decides more intense review is needed. | | | |
| 1989 | | 43,616 | 28,292 | 503.8 |
| Apr. | HCFA finds HMO's QA and utilization management (UM) deficient—lacks systematic data. Corrective action plan (CAP) required. | | | |
| 1990 | | 68,744 | 31,055 | 609.8 |
| Nov. | HCFA finds HMO's QA and UM deficient, requires CAP. | | | |
| 1991 | | 54,033 | 32,862 | 780.4 |
| Aug. | PRO concern with quality warrants intensified review. | | | |
| Oct. | HCFA certifies that QA, UM requirements met, but requests intensified reporting. | | | |
| 1992 | | 43,535 | 38,180 | 884.4 |
| Jan. | HCFA announces special PRO review to verify HMO's QA improvements since earlier findings. | | | |
| 1993 | | 41,405 | 40,086 | 1,005.6 |
| Jan. | PRO study shows quality problems in 27 of 109 hospitalization cases and in 22 of 30 complaints. | | | |
| Feb. | HCFA elects to study PRO data further. | | | |
| June | PRO data show quality problems at most Florida Medicare HMOs. Routine HCFA visit to the HMO finds no QA problems. | | | |
| 1994 | | 46,029 | 37,602 | 1,062.5 |
| Jan. | PRO reports HMO has not taken corrective actions on PRO quality problems raised since 1992. | | | |
| June | NCQA denies the HMO's South Florida market accreditation. HCFA announces investigation of the HMO's South Florida operations and plans investigations of other Florida HMOs. | | | |
| Sept. | HCFA finds HMO's QA and UM deficient. HMO has modifications in process. | | | |

(continued)

| Time frame | Activity | New enrollment in year | Disenrollment in year | Medicare payments (millions) |
|-------------|---|------------------------|-----------------------|------------------------------|
| 1995 | | | | |
| Jan. | HCFA accepts HMO's CAP addressing QA and UM weaknesses noted in 9/94 investigation. PRO reports HMO's 1994 incidence of confirmed quality problems is lower than average for Florida Medicare HMOs. | | | |
| May | HCFA conducts follow-up visit to review HMO's progress in implementing CAP. | | | |
| July | HCFA finds HMO in compliance with federal requirements on the basis of evidence of corrections from January and May 1995 site visits. | | | |

Source: HCFA.

Slow enforcement by HCFA was not unique to quality problems, or to the Florida market. Two other enforcement cases we reviewed to test HCFA's processes were in California and Illinois and included

- marketing abuses, including high-pressure, illegal practices resulting in high levels of complaints and disenrollments from misinformed beneficiaries (see p. 12);
- nonpayment or slow payment of claims for beneficiaries' out-of-plan services, which can result in out-of-pocket expenses or bill collection actions against the beneficiaries; and
- not following prescribed appeal processes, resulting in some Medicare beneficiaries not receiving the services they are entitled to under the HMOs' Medicare contracts (see p. 13).

Limited Oversight of Medicare HMO Quality Assurance

HCFA's monitoring and certification process has not been adequate to ensure that Medicare HMOs comply with standards for ensuring quality care. This has been confirmed by HCFA, PRO, and NCQA findings showing a mismatch between what HMOs are supposed to do and what they actually do to manage and ensure quality of care. NCQA recently found many HMOs out of compliance with its standards.⁴ Of the 15 Florida Medicare plans NCQA had reviewed as of December 1994, only 1 received full accreditation, 8 received less than full accreditation, and 6 were denied accreditation.

⁴Of plans reviewed nationally, 33 percent of HMOs requesting NCQA review received full accreditation, 53 percent received less than full accreditation, and about 13 percent were denied accreditation. These figures include a portion of Medicare HMOs. By the end of 1995, NCQA will have reviewed 80 Medicare HMOs accounting for two-thirds of Medicare HMO enrollment.

HCFA efforts to ensure that Medicare beneficiaries receive quality care from HMOs continues to be inadequate for three reasons. Specifically, HCFA

- conducts limited quality assurance reviews,
- does not routinely collect utilization data that could most directly indicate potential quality problems, and
- does not assess HMO risk-sharing arrangements with providers that can trigger quality problems.

Limited Quality Assurance Reviews

HCFA's routine compliance monitoring reviews do not go far enough to verify that HMOs monitor and control quality of care as federal standards require. The reviews check only that an HMO has procedures and staff capable of quality assurance and utilization management—they do not check for effective operation of these processes. While HCFA has PROs under contract to review the medical care provided to HMO enrollees, HCFA does not link its contract compliance monitoring with PROs' monitoring, nor does it draw on PRO staff expertise that could help verify whether HMOs' quality assurance programs actually work. This explains why PROs were able to identify patterns of quality of care problems—as they did in 1988, 1991, and 1993 at the South Florida HMO—at the same time HCFA contract monitors cited no problems with the HMO's compliance with quality standards.

HCFA's routine review and certification of an HMO's quality assurance program is completed without the participation of trained clinical staff and without systematic consideration of PRO findings. A routine HCFA review visit at an HMO generally involves about three people, without specialized clinical or quality assurance training, who spend a week or less focused largely on Medicare requirements for administration, management, and beneficiary services rather than on medical quality assurance. About a third of staff time is typically spent on quality-related matters. Monitoring officials of HCFA headquarters and in regions expressed the need for added trained staff to properly assess HMOs' quality assurance systems.

In contrast with HCFA's approach, NCQA reviews last about a week, but focus primarily on quality assurance. The NCQA review team typically consists of three people, including two physicians and another clinician or administrator experienced in HMO operations. In addition to reviewing an HMO's quality assurance program design, NCQA reviewers also test it by reviewing records and interviewing providers, to assess whether the system is functioning as designed.

Since 1994, HCFA has been studying ways to improve both quality standards for HMOs and its methods for reviewing quality assurance. Through these efforts, HCFA is seeking to improve its current HMO certification process and to assess ways to coordinate with other organizations that oversee HMOs. Three other internal HCFA studies of its quality assurance certification practices were done over the past 2 years.

Little Information on HMOs' Services Currently Available to Enrollees

Another factor limiting the effectiveness of HCFA's monitoring of quality of care in HMOs has been the lack of data on beneficiaries' utilization of services. In the fee-for-service sector, claims data are available and can be used to detect potential overutilization of services. No comparable data exist in the Medicare HMO program to detect potential underutilization. As a result, even such basic information as hospitalization rates; the use of home health care; or the number of people receiving preventive services, such as mammograms, is unknown.

Federal standards require that HMOs have information systems to report utilization data and management systems to monitor utilization of services. Yet HMOs often lack these data, and HCFA has not required that such data be standardized or that the data be submitted to HCFA and to the PROS. HCFA has broad legal authority to require that HMOs regularly report a wide variety of statistical information to the federal government. This includes specific authority to require data on patterns of utilization of medical services in HMOs, and the availability and acceptability of those services.

In contrast with HCFA, the private sector has, over the past few years, moved to develop information and data standards that could enable purchasers and consumers to compare different HMOs. To enable such assessment of health plans' cost effectiveness and performance, a group of large employers and HMOs working with NCQA are developing the Health Plan Employer Data and Information Set (HEDIS). These data constitute a set of performance measures to evaluate plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. Some employers already require their plans to submit HEDIS-based information.

HCFA has now picked up on the private sector's approach and has begun developing HEDIS-type HMO performance measures geared to services provided to elderly Medicare beneficiaries. A test of an initial set of measures covers the preventive services of flu immunization and

mammography screening and will document the care of beneficiaries with diabetes. HCFA recently began testing the measures in 5 states and 23 HMOs.

Little Attention Paid to Risk-Sharing Arrangements

HCFA's HMO quality assurance monitoring processes also do not adequately address risk-sharing arrangements between HMOs and their providers. The agency does not routinely assess whether HMO risk-sharing arrangements create a significant incentive to underserve, although the Congress gave the Department of Health and Human Services (HHS) authority, beginning April 1, 1991, to limit arrangements that it found provided excessive incentive to underserve. As of April 1995, HHS was still developing regulations and had not developed methods for gauging how much risk an HMO can legitimately pass to providers, or requirements that providers must meet to accept such risk.

One HMO that a PRO identified as having an unusually high number of quality of care problems has been a concern to HCFA reviewers for several years because of its financial risk arrangements with providers. Under its risk-sharing arrangement, the HMO takes about 23 percent of its capitated payment for ambulatory services to administer the program and uses the remaining 77 percent to make capitated payments to providers. Over the years, several providers have lost money on care they provided to the HMO's patients.

These providers—often individual physicians or small physician groups—are financially responsible to provide the HMO's enrollees all of their needed ambulatory services. Under such arrangements, every time a patient uses a primary care physician or specialist, or obtains diagnostic tests, the money comes out of the capitated payments the HMO makes to the provider responsible for delivering and managing the care. This could give providers financial incentives to withhold services, particularly if they are losing money on the HMO's patients.

HCFA Reluctant to Fully Utilize Enforcement Authority

In 1988 and again in 1991 we reported that HCFA was not using its enforcement authority effectively to obtain corrective action from those HMOs that were slow in correcting problems.⁵ As highlighted earlier, the cases we reviewed for this report illustrate this problem.

⁵Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988) and Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

The Congress granted HCFA authority to impose sanctions or monetary penalties on HMOs that fail to meet federal standards. HCFA's sanction authorities include stopping enrollment, stopping payment for new Medicare enrollees, imposing monetary penalties, and revoking Medicare contracts. HCFA can impose these sanctions or penalties for such actions as abusive marketing or underserving beneficiaries. Although the Congress first gave HCFA sanction authority in 1986, it was not until 1994 that HCFA issued regulations implementing this authority.

Pursuing sanctions against noncompliant HMOs can be an administratively cumbersome and staff-intensive process, according to HCFA officials. HCFA's enforcement approach is to seek to document the causes of an HMO's problems and to attempt to get the HMO to correct problems, without resorting to sanctions.

Under this approach, after HCFA staff show that an HMO is not meeting federal standards, the HMO then has an opportunity to address deficiencies by developing a corrective action plan. If the HMO does not implement the corrective action or the action is inadequate, then HCFA staff investigate the HMO's operations to further document the problems. An investigation could result in HCFA finding noncompliance and requesting a new corrective action plan. The process can then repeat itself.

The outcome of this approach is that an HMO, without sanction, can take years before correcting identified deficiencies. We question whether this serves the best interests of Medicare or HMO beneficiaries. Two cases illustrate this:

- An Illinois HMO enrolled 29,600 people during a period of marketing abuses. In 1991, while the HMO was under investigation nationally for Medicare HMO marketing abuses, it purchased an Illinois HMO with a Medicare contract. By early 1992, HCFA noted that one-third of new enrollees in the plan disenrolled within 3 months. Moreover, HCFA began receiving beneficiary complaints about salespersons' misrepresentations and high-pressure tactics. HCFA's March 1994 review of the HMO's marketing cited numerous instances of deceptive and high-pressure sales tactics, including misrepresentation. HCFA also found instances of prohibited payments or gifts to induce people to enroll. In April 1994, the HMO submitted a corrective action plan addressing its marketing tactics and supervision of commissioned sales agents. In August 1994, HCFA and the HMO agreed on milestones for lowering the HMO's disenrollment rates. HCFA

is monitoring the HMO's progress toward lowering its disenrollment and complaint rates. (See table I.1.)

- A California HMO tripled Medicare membership during a period when provider claims were not promptly paid and beneficiaries did not receive their appeal rights. HCFA's 1992 monitoring report noted the HMO's late payment of claims from providers and failure to process beneficiary appeals in a timely manner. The HMO submitted a corrective action plan to HCFA and for the next 2 years reported progress in achieving compliance. In 1994, however, HCFA found that the problems persisted. HCFA concluded that the HMO lacked sufficient staff and systems to organize, plan, control, and evaluate the administrative and management aspects of its Medicare operations. For example, HCFA found that the HMO failed to pay in a timely manner over 64 percent of the claims in a sample HCFA reviewed. In over 62 percent of a sample of appeals cases, HCFA found that the HMO failed to forward beneficiaries' appeals to HCFA within the specified 60 days. HCFA's February 1995 visit found that the HMO had made substantial improvements in processing claims and appeals, although problems remained. HCFA found additional unrelated problems as well. The HMO submitted a corrective action plan—its third in 3 years—in April 1995. In May 1995, HCFA approved most of the elements in the plan. The HMO submitted a revised corrective action plan addressing the remaining elements in June 1995. (See table I.2.)

HCFA does not routinely release the results of its monitoring visits, or the comparative performance indicators it collects, to the public. Consequently, when an HMO violates federal standards, Medicare beneficiaries could remain unaware of problems that could influence their decision to join or remain enrolled in that HMO. HCFA's reluctance to disclose HMO-specific information it develops can work to the benefit of poor-performing HMOs, to the detriment of beneficiaries who make less-informed selections, and to the detriment of HMOs that comply with standards.

Appeal Process Is Slow and Places Beneficiaries at Financial Risk

Although intended to be a beneficiary protection against potential underservice by HMOs, the appeal process is too slow to effectively resolve disputes over services that beneficiaries believe are urgently needed. Moreover, some HMOs have extended the process even more by not processing beneficiaries' appeals within the prescribed time frames. This results in some beneficiaries returning to fee-for-service Medicare to

obtain the services they believe they need, while others remain in HMOs but incur substantial out-of-pocket expenses with little certainty of repayment.⁶

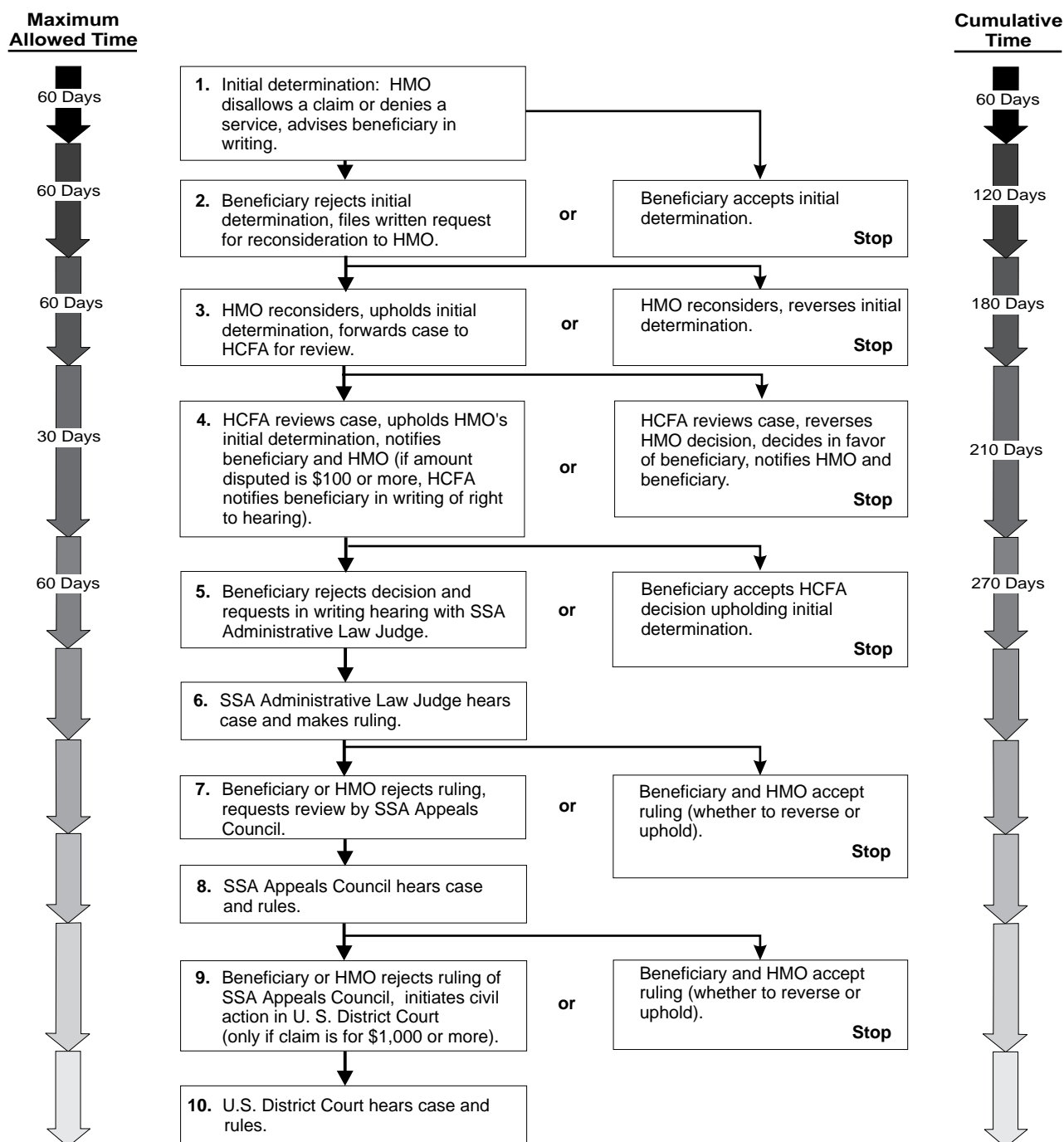
Under Medicare regulations, beneficiaries in HMOs may appeal denials of service or the HMO's refusal to pay for services obtained from out-of-plan providers.⁷ The appeal process requires first that the HMO deny the service and second that the beneficiary ask for a reconsideration of the denial. If the reconsideration decision is not fully favorable to the beneficiary, the HMO is required to send the denial, along with medical information concerning the disputed services, to a HCFA contractor that adjudicates such denials. Since 1989, HCFA has performed its appeal reconsideration function through a contractor—the Network Design Group (NDG) of Pittsford, New York. NDG hires physicians, nurses, and other clinical staff to evaluate beneficiaries' medical need for contested services and make reconsideration decisions.

Under current HCFA standards, the process allows up to 6 months from the initial determination before an HMO must forward an appeal to HCFA, as shown in figure 1. Some HMOs take longer than HCFA standards, contributing to further delays. For instance, although HCFA allows HMOs a maximum of 60 days to reconsider a beneficiary's appeal, HCFA has found that several HMOs in California and Florida inappropriately retained beneficiary appeals between 130 and 200 days, on the average, before forwarding them to HCFA's adjudication contractor.

⁶A HCFA-sponsored study reviewed a sample of beneficiary appeals for 1991 and found that 42 percent of the beneficiaries disenrolled from their HMOs within 2 years following the disputed services, of which 63 percent disenrolled within 90 days after their cases were decided by HCFA.

⁷Out-of-plan services must be covered by an HMO if the service is an emergency or the enrollee is out of the HMO's operations area and urgently needs the service.

Figure 1: Medicare Appeal Process



Beneficiaries appealing their HMOs' coverage denial for nursing home care, home health care, or urgently needed care may find the process does not work quickly enough. In addition to the time it takes for an appeal to reach HCFA, most cases that reach HCFA for reconsideration have taken longer to resolve than the target of 30 days that HCFA and its contractor strive for. In 1993, 38 percent of appeals to HCFA were straightforward enough for HCFA's contractor to decide within 30 days. About 45 percent required about 3-1/2 months. More complex cases, where medical information was missing or where Medicare coverage rules were unclear, took over 6 months.

Three examples illustrate how the process works for Medicare beneficiaries:

- A newly enrolled beneficiary requested physical therapy from an HMO physician to alleviate back pain. The beneficiary had suffered for years from severe back problems, which had been controlled by physical therapy. Although the HMO physician prescribed 17 sessions of physical therapy, the plan covered only one session. The beneficiary unsuccessfully appealed to the HMO and HCFA. More than a year after her therapy services were denied, the beneficiary was still waiting for a decision from an Administrative Law Judge.
- A beneficiary finding himself unable to walk or urinate was admitted to a hospital not affiliated with his HMO. He was discharged 2 weeks later only to be readmitted the next day after falling at home. The HMO denied the hospital's claim for \$23,600 in services because it did not consider the need for care an emergency. The hospital billed the beneficiary. HCFA's reconsideration contractor concluded that the hospital services were needed to prevent renal failure, infection, and other complications. HCFA's contractor found the HMO liable for the cost of the hospital services—over 7 months after the HMO's initial denial.
- Following surgery for lung cancer, a beneficiary repeatedly complained of pain and tenderness in the chest. X rays done shortly after surgery indicated possible remaining cancer, but no follow-up was done. After 14 months of continued complaints of pain, externally visible swelling led to new tests and the diagnosis that cancer had spread to the chest wall. An HMO oncologist explained that the only treatment available through the HMO had a modest success rate, and expressed willingness to refer the patient to a non-HMO center offering another treatment with a reported high success rate. The HMO denied the beneficiary's request. The beneficiary requested the services two more times. Although the HMO denied the services three times, it did not inform the beneficiary of his right to appeal. The HMO forwarded the case to HCFA for reconsideration.

after the third denial. At this point, the beneficiary learned from HCFA's contractor of the ongoing appeal and his right for reconsideration. HCFA's contractor upheld the HMO denial because of the experimental nature of the requested treatment and because the HMO offered a treatment considered appropriate. The beneficiary paid for \$13,000 in services he obtained from the non-HMO center prior to deciding to return to fee-for-service, where Medicare covered the treatment for some beneficiaries.

Medicare HMO beneficiaries who pay for services they believe are needed may be liable for those costs. In 1994, HCFA decided over 3,100 appeals, 80 percent of which were denied claims for reimbursement of services obtained from providers not affiliated with the HMO. The average claim was about \$4,300, totaling over \$15 million in disputed claims. HCFA's reconsideration contractor upheld HMO denials in 64 percent of the appeals, leaving beneficiaries liable for over \$11 million in claims.

HCFA is aware of the potential for improving the appeal process and has taken some steps toward this end. In November 1994, HCFA clarified its rules, allowing a beneficiary to appeal without a written denial notice from the plan. This could remove a significant barrier that beneficiaries in some HMOs faced in initiating appeals.

HCFA also issued a rule in November 1994 extending to beneficiaries in HMOs the right to obtain expedited PRO review of HMO decisions to discharge them from a hospital. Since 1986, fee-for-service Medicare beneficiaries have been able to request such a PRO review of a hospital's discharge order when they believe they should remain hospitalized.

HCFA operations officials also recognize the potential for further improvements. They have proposed an expedited review process for decisions on care perceived as urgently needed. They also propose to look at ways to better educate beneficiaries on their appeal rights and the appeal process.

Private Sector Developments in HMO Quality Oversight

Some large employers, acting as the sponsor of their employees in selecting health care plans, have begun to use accreditation and performance data in checking HMOs' value, and in deciding whether to accept an HMO into their health plans. Nearly half the HMOs in the country will have undergone NCQA review by the end of 1995. NCQA accreditation focuses primarily on standards related to quality assurance and use of

services—the areas in which federal certification reviews are relatively weak. The HEDIS performance measurement set is expected to take the place of the varying data requests employers already make to evaluate plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability.

The private sector also disseminates quality-related information to purchasers and users. NCQA publicizes its accreditation decisions, which allows employers and employees to consider accreditation status in their HMO decisions. The effect is that HMOs that do not obtain accreditation can lose business. For example, a consortium of employers has elected to exclude a Florida HMO from new business with their employer-sponsored health plans because of the HMO's failure to obtain accreditation.

HCFA is the sponsor for Medicare beneficiaries in the selection and oversight of Medicare contract HMOs, much like employers are for their employees' health plans. HCFA, however, does not routinely provide beneficiaries the results of its monitoring reviews or other performance-related information such as HMO disenrollment rates or beneficiary complaints. HCFA does routinely collect and analyze data on Medicare HMOs' enrollment and disenrollment rates, appeals, beneficiary complaints, financial condition, availability and access to services, and marketing strategies.

Other Ongoing Improvements in HCFA's Medicare HMO Contract Oversight

HCFA has made ongoing improvements that enhance its ability to monitor HMOs and enforce federal standards. These improvements in HMO contract oversight are in addition to those already mentioned. For example, HCFA has progressively improved its collection and summarization of comparative performance indicators on individual HMOs and makes these available to contract monitoring staff. This can aid HCFA in detecting problems in some cases. The indicators include enrollment and disenrollment statistics, including rapid or early disenrollments, and rates of beneficiaries' appeals of denied care. In addition, three HCFA regional offices, accounting for about three-fourths of Medicare HMO enrollments, have implemented an automated tracking system for complaints.

Beginning in 1994, HCFA has more aggressively used its regulatory authority under title 13 of the Public Health Service Act to get at root causes of HMO quality assurance problems. HCFA officials explained that they use the results to work cooperatively with plans' top management to correct weaknesses. Four investigations have been conducted since July 1994 on

HMOs with apparent quality assurance problems, and a fifth was recently started. The first three of these investigations were done at Florida HMOs and resulted in findings of noncompliance with federal standards. The experience of designing and conducting these investigations provides an excellent basis for HCFA to design routine monitoring reviews that test HMOs' internal quality assurance. However, the experience gained from these investigations shows that increased staffing with better training or qualifications may be necessary for HCFA's routine monitoring.

HCFA also announced that it plans to begin site visits to HMOs annually, beginning in fiscal 1996. Annual reviews may benefit where HCFA needs follow-up verification that HMOs have corrected deficiencies. They also may permit HCFA to focus in any one year on a particular aspect of HMO operations, potentially increasing effectiveness.

Conclusions

HCFA recognizes that it needs to be more active as a sponsor for beneficiaries enrolling in Medicare HMOs. This entails selecting qualified HMOs to participate in the program, protecting beneficiaries' interests after they join an HMO, and informing beneficiaries of HMO performance. Although HCFA, to its credit, has taken a number of positive actions, it has not

- adequately developed and staffed routine monitoring of HMOs' quality assurance and other key operations to protect beneficiaries' interests;
- taken actions to obtain prompt compliance with existing quality-of-care or other beneficiary protection standards from those HMOs that are slow to correct problems; or
- given Medicare beneficiaries available information that could help them decide to enroll or to remain enrolled in an HMO.

Moreover, HCFA has not issued regulations, originally called for in 1986 legislation, defining acceptable levels of financial risk an HMO can transfer to subcontracted providers.

Private sector progress, weighed against continued shortcomings in HCFA's current compliance approach, suggests that HCFA needs to overhaul its compliance approach to be more consumer-oriented. This would include forbidding noncompliant HMOs from continuing to enroll beneficiaries, and publishing available data that beneficiaries can use to gauge HMOs' relative performances. In addition, HCFA could strengthen its quality assurance review efforts and streamline its beneficiary appeal process. We have

recommended a variety of similar changes over the past decade and have observed some improvements in monitoring. But HCFA has remained reluctant to take strong enforcement actions and continues to rely on reviews of HMOs' quality assurance practices that do not verify their effectiveness.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of HHS direct the HCFA Administrator to develop a new, more consumer-oriented strategy for administering the Medicare HMO program. This should include directing that HCFA

- routinely publish (1) comparative data it collects on HMOs such as complaint rates, disenrollment rates, and rates and outcomes of appeals, and (2) the results of its investigations or any findings of noncompliance by HMOs;
- verify the effective operation of all HMOs' quality assurance and utilization management practices, by applying sufficient trained staff during routine monitoring, and integrating PRO findings into HCFA's compliance monitoring reviews; and
- explore further options to streamline the appeal process.

Agency Comments

The Department of Health and Human Services disagreed with many of the report's findings, emphasizing that the report discusses monitoring and enforcement problems that occurred years ago and largely ignores substantial changes made in the last 2 years. HHS agreed, however, that there is room for improvement in the appeal process and in providing information to consumers. The full text of HHS' comments appears in appendix III.

With regard to HHS' concerns about our use of old information, the three enforcement cases presented in this report were as timely a test of HCFA processes as we could select at the time of our review. They were the only cases identified by HCFA as either under investigation or having the potential for legal action when we began our fieldwork in June 1994. In addition, the South Florida quality assurance monitoring case was the first HMO to undergo HCFA's enhanced investigation effort to get at root causes of problems.

HHS was also concerned that we did not examine important initiatives HCFA has recently undertaken to improve its HMO quality assurance monitoring. On the basis of additional information provided by HHS, we revised the

report to recognize those initiatives that were relevant to the issues we addressed. Although we agree that HCFA's recent efforts have improved its monitoring capability, they do not change our conclusion that HCFA's routine monitoring of HMOs' quality assurance practices does not go far enough to verify compliance with federal requirements. This is primarily an issue of applying sufficient and appropriately trained staff to the task, something recognized by HCFA's own internal studies and endorsed by HCFA operations staff we met with. Other issues that affect the quality of this monitoring—including the clarity and currency of regulations and standards—are the subject of ongoing HCFA studies.

HHS also disagreed with our position "that the number of times HCFA levies monetary penalties against HMOs is a measure of the intensity of . . . [the agency's] . . . oversight efforts." While we agree with HHS that monetary penalties can "simply become a cost of doing business for HMOs," our point is that more aggressive enforcement can be more effective in bringing about HMO compliance. Our emphasis was on limiting HMOs' enrollment of new members as a penalty until the HMOs can clearly demonstrate that they have identified and corrected the root causes of problems. Our report also highlights another method of enforcing HMO compliance, which focuses on providing comparative HMO performance information to Medicare beneficiaries, who make marketplace decisions in selecting particular HMOs.

HHS noted that we should have more comprehensively compared HCFA and NCQA quality assurance standards. This was not done for two reasons. The difference between NCQA and HCFA reviews that we judged most relevant was that NCQA reviews apply sufficient numbers of trained staff to provide some verification that HMOs have effective quality assurance and utilization management operations, while HCFA's routine reviews do not. The requirement for effective quality assurance and utilization management is common to both organizations' standards. Also, HCFA had a contract in process to compare its standards and review process with NCQA's and with several others.

In the final analysis, our report emphasizes that HCFA is the primary sponsor of Medicare beneficiaries' interests when they enroll in HMOs. As such, HCFA has a responsibility to be proactive in its role, by collecting and publishing data to consumers in the marketplace, and by acting quickly and firmly to protect beneficiary interests when it has indications of poor care or abusive practices.

As arranged with your offices, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services. We will also make copies available to others upon request.

If you or your staffs have any questions about this work, please call me on (202) 512-7123. Major contributors to this report are listed in appendix IV.

Sincerely yours,

A handwritten signature in black ink that reads "Sarah F. Jaggar". The signature is written in a cursive style with a large, looping "S" and "J".

Sarah F. Jaggar
Director, Health Financing
and Public Health Issues

Contents

| | | |
|---|---|----|
| Letter | | 1 |
| Appendix I Chronology of Events in Two Recent Enforcement Cases | | 26 |
| Appendix II Scope and Methodology | | 29 |
| Appendix III Comments From the Department of Health and Human Services | | 30 |
| Appendix IV Major Contributors to This Report | | 34 |
| Related GAO Products | | 36 |
| Tables | Table 1: An Example of an Ineffective Compliance Effort | 7 |
| | Table I.1: An Illinois HMO Marketing Case History | 26 |
| | Table I.2: A California HMO Case History—Claims, Appeals, and Enrollment Processing | 27 |
| Figure | Figure 1: Medicare Appeal Process | 15 |

Abbreviations

| | |
|-------|---|
| CAP | corrective action plan |
| HCFA | Health Care Financing Administration |
| HEDIS | Health Plan Employer Data and Information Set |
| HHS | Department of Health and Human Services |
| HMO | health maintenance organization |
| NCQA | National Committee for Quality Assurance |
| NDG | Network Design Group |
| PRO | peer review organization |
| QA | quality assurance |
| SSA | Social Security Administration |
| UM | utilization management |

Chronology of Events in Two Recent Enforcement Cases

Table I.1: An Illinois HMO Marketing Case History

| Time frame | Activity | New enrollment in year |
|-------------|--|------------------------|
| 1990 | | |
| Jan. | HCFA reviews plan that the HMO proposes to purchase. Based on troubles in Florida and Texas, HCFA starts investigation of marketing in all the HMO's markets. Investigation continues through 1992. | |
| 1991 | | 1,525 |
| Feb. | HCFA notes that the HMO plans to raise marketing budget from \$2.4 million to \$6.4 million in fiscal 1991. | |
| Mar. | The HMO completes purchase of Chicago HMO. | |
| 1992 | | 7,584 |
| Mar. | HCFA requests that HMO investigate high rate of early disenrollments and complaints about marketing. HMO agrees that data indicate problem. | |
| Dec. | HCFA and HMO debate disenrollment data. | |
| 1993 | | 8,123 |
| Feb. | Routine HCFA site visit. | |
| June | HCFA site visit report notes marketing area "met," but disenrollments continue to be twice the national average. HCFA to continue to monitor. | |
| Sept. | HCFA asks HMO to investigate complaints about high-pressure and illegal marketing practices. | |
| Dec. | HCFA meets with HMO to "encourage" it on sales agent turnover, early disenrollment. HMO questions the accuracy of HCFA's disenrollment data. | |
| 1994 | | 12,360 |
| Jan. | HCFA decides to review HMO's marketing operations. | |
| Mar. | HCFA conducts marketing review, then issues formal notice of investigation asking what the HMO will do to correct apparent violations of Medicare law. HCFA also threatens notice in <u>Federal Register</u> and suspension of enrollment. | |
| Aug. | HCFA acknowledges HMO's corrective action plan and timetable to reduce early disenrollments. | |
| Nov. | HMO reports progress in reducing rate of early disenrollment. | |
| 1995 | | 3,802 |
| Apr. | Target date for closing title 13 investigation. | |

Source: HCFA.

Appendix I
Chronology of Events in Two Recent
Enforcement Cases

Table I.2: A California HMO Case History—Claims, Appeals, and Enrollment Processing

| Time frame | Activity | New enrollment in year |
|-------------------|---|-------------------------------|
| 1990 | | 66 |
| Aug. | The HMO enters a Medicare risk contract as a competitive medical plan. | |
| 1991 | | 5,215 |
| Feb. | HMO obtains its first service area expansion. | |
| 1992 | | 6,244 |
| Apr. | HCFA conducts its first monitoring visit and finds that HMO lacks systems to ensure timely payment of claims and notification of denials. | |
| July | HCFA approves a new service area expansion that was pending at the time of first monitoring visit. HCFA report of first visit informs HMO that HCFA will withhold approval of any expansions until acceptable corrective action is implemented. | |
| Aug. | HMO submits a corrective action plan (CAP). | |
| Sept. | HCFA finds HMO's CAP insufficient to improve claims processing. HCFA meets with the HMO to discuss revisions to CAP. | |
| 1993 | | 10,009 |
| Jan. | HMO submits an entirely new CAP addressing claims processing deficiencies. | |
| Feb. | HMO is granted third service area expansion. | |
| Mar. | HCFA approves HMO's CAP. | |
| 1992-1994 | HMO sends HCFA three progress reports indicating its medical groups are in compliance or near compliance with federal claims processing requirements. | |

(continued)

Appendix I
Chronology of Events in Two Recent
Enforcement Cases

| Time frame | Activity | New enrollment in year |
|-------------------|--|-------------------------------|
| 1994 | | 13,503 |
| Mar. | HCFA's routine monitoring visit finds that claims processing problems persist; HMO does not provide beneficiaries notice of denials and does not notify beneficiaries of reconsideration decisions within the allowed 60 days. | |
| Apr. | HCFA monitoring report stops further service area expansion until HMO can demonstrate that its operations are in compliance with Medicare standards. | |
| May | HCFA sends HMO a letter of concern because several of the problems addressed in the 1992 monitoring report and corresponding CAP persisted. HMO submits a CAP in response to the 1994 monitoring report. | |
| June | HCFA approves 8 of 19 elements of HMO's CAP. | |
| July | HMO submits a significantly revised CAP to HCFA. | |
| Aug. | HCFA approves the 11 remaining elements of HMO's CAP. | |
| Nov. | HCFA review of inquiries and complaints received from HMO's members indicates problems in enrollment and disenrollment. HCFA asks HMO to investigate. | |
| Dec. | HCFA evaluates HMO's response. Because of problems in the HMO's operations, HCFA warns HMO it will evaluate the necessity of terminating Medicare contract. | |
| 1995 | | 3,550 |
| Jan. | HCFA meets with HMO's Chief Executive Officer over concerns raised by the influx of member-specific problems received by HCFA. | |
| Feb. | HCFA conducts a follow-up visit. | |
| Mar. | HCFA reports substantial improvements in HMO's processing of claims and appeals, but finds significant problems in HMO's handling of enrollments and disenrollments. | |
| Apr. | HCFA returns HMO's application for a fourth service area expansion, until HMO can demonstrate compliance with enrollment/disenrollment requirements. HMO submits a third CAP. | |
| May | HCFA approves 10 of the 14 elements in HMO's CAP. | |
| June | HMO submits a new CAP on the rejected elements. | |

Source: HCFA.

Scope and Methodology

We reviewed HCFA's current HMO monitoring and enforcement practices and discussed them with managers and staff at HCFA's Office of Managed Care, Health Standards and Quality Bureau, Region IX—San Francisco, Region IV—Atlanta, and Region V—Chicago. In addition, we interviewed the PROs for California and Florida to obtain their views about the Medicare HMO oversight process. We accompanied HCFA on an investigation of quality assurance practices at a Florida-based HMO with a Medicare contract. In addition, we selected ongoing enforcement cases to verify the effectiveness of HCFA's oversight practices. We contacted officials from the HMOs cited as examples in this report.

We reviewed the statutory and regulatory requirements for the appeal process and discussed them with HCFA staff at the Office of Managed Care. We also interviewed a representative of Network Design Group, HCFA's contractor for processing appeals. In addition, we obtained and analyzed data on the timeliness, types, and outcomes of beneficiary appeals to HCFA. We also discussed with HCFA officials proposals for improving the appeal process.

We discussed federal, state, and private review, licensing, and accreditation practices with officials from Florida's Agency for Health Care Administration, the National Committee for Quality Assurance, the Group Health Association of America, and the Los Angeles-based consumer advocacy group, Center for Health Care Rights. We also discussed beneficiaries' rights to appeal denials of care with this group.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 29 1995

Ms. Sarah F. Jaggar
Director
Health Financing and
Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Enclosed are the Department's comments on your draft report, "Medicare: Federal Oversight of HMOs Has Not Assured Beneficiary Protection." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,


June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Appendix III
Comments From the Department of Health
and Human Services

Comments of the Department of Health and Human Services
on the General Accounting Office (GAO) Draft Report,
"Medicare: Federal Oversight of HMOs Has Not Assured
Beneficiary Protection"

At the request of the Ranking Minority Member of the Senate Special Committee on Aging, GAO reviewed Federal oversight of health maintenance organizations (HMOs) that enroll Medicare beneficiaries. Specifically, this report responds to the Senator's interest in (1) the Health Care Financing Administration's (HCFA's) monitoring of HMOs' compliance with Federal quality assurance standards, (2) HCFA's enforcement actions against HMOs that do not meet Federal standards, (3) the effectiveness of the beneficiary appeals process, and (4) the approaches the private sector is taking to assure HMO enrollees of quality care.

The Department disagrees with many of the findings. In general, the report discusses monitoring and enforcement problems that occurred years ago while largely ignoring the substantial changes we have initiated in the last 2 years. These changes have created more effective monitoring and oversight activities, which in turn yielded better quality of care for Medicare beneficiaries.

While we are disappointed that GAO did not examine the substantial changes that have been made in the HMO oversight program since 1993, we appreciate Senator Pryor's ongoing interest in the quality of care provided to Medicare beneficiaries, and we look forward to continuing to work with him and his staff on further improvements.

We believe that four major issues in the report particularly merit comment:

- 1) **The report asserts that the HCFA enforcement process is little more than a paper documentation process which has not resulted in the improvement of quality of care for Medicare beneficiaries.**

The Department is keenly interested in assuring that as the Medicare managed care program grows and evolves, we have adequate monitoring processes in place to assure and improve the quality of the care provided.

Under the Clinton Administration, HCFA has made significant improvements in its monitoring and oversight of managed care contracts, and we are planning additional improvements.

Appendix III
Comments From the Department of Health
and Human Services

- Most notably, in 1994 HCFA initiated an aggressive enforcement process to remedy root causes of quality and access problems. In the four investigations completed to date, improvements have been made in the HMOs' operations that have resulted in a substantial decrease in the number of consumer complaints and fewer problems being identified in ongoing Peer Review Organization (PRO) review. HCFA has obtained enrollment freezes in instances when beneficiaries may not have been appropriately served.
- HCFA's monitoring protocol and procedures were substantially changed in 1993 and again in 1995. These modifications enhance HCFA's evaluation of health service delivery systems, quality assurance programs, claims payment procedures, and other areas of managed care operations.
- HCFA is in the process of implementing the Managed Care Quality Improvement Program (MCQIP), which would continue to improve quality monitoring by the PROs. The MCQIP would shift the PROs' focus away from medical record review toward the development of performance indicators and cooperative improvement projects between the PROs and HMOs.
- HCFA has recently begun collaborating with the National Committee on Quality Assurance (NCQA) to expand the Health Plan Employer Data Information Set to include performance indicators relevant to the Medicare population.
- HCFA is convening a series of meetings with public and private purchasers of health care services, consumer groups and managed care plans to discuss issues regarding the collection of encounter data. We believe that such data are crucial to advances in quality assurance systems.
- HCFA recently announced that we will begin annual, rather than biannual, on-site monitoring in 1996.
- 2) **The report states that HCFA is reluctant to use various civil monetary penalties to enforce compliance among Medicare HMOs.**

As noted above, HCFA shifted to a more aggressive enforcement process in 1994. We also believe that both Medicare beneficiaries' interests and the program's interest are better served if HMOs have the opportunity to correct problems voluntarily before fines or penalties are imposed. We are pleased that, in every investigation we have initiated under this approach, target HMOs voluntarily froze enrollments and took other actions at HCFA's request to ensure the provision of quality care while deficiencies were being corrected.

Hence, we disagree that the number of times HCFA levies monetary penalties against HMOs is a measure of the intensity of our oversight efforts. Under an approach that focuses on monetary penalties without reference to corrective action, beneficiaries may be needlessly alarmed and their health care disrupted. Further, such penalties could simply become a cost of doing business for HMOs.

3) The report asserts that HCFA does little to provide consumers with information on problems identified in Medicare HMOs.

Private sector purchasers, health plans and organizations such as NCQA have only recently begun developing information in a format that would be useful to consumers in evaluating the quality of care provided by health care plans. There is little consensus regarding the most effective method to convey this information.

Improving consumer information is a high priority for HCFA, and we agree that there is room for improvement in this area. We are currently working with beneficiary advocacy groups to learn what kinds of information consumers want and need. In addition, as part of a competitive pricing demonstration, HCFA will be exploring how best to communicate comparative information to beneficiaries regarding their managed care choices.

While we are very interested in providing information to consumers, our efforts to reveal the findings from our investigations are constrained by the following. There are statutory limitations on disclosure of business-related information and the information is not in a form that is useful to consumers.

4) The report indicates that the appeals process could be improved.

As the report indicates, we have taken action to improve the appeals process and are currently determining how best to provide for expedited appeals.

Technical Comment

The report compares HCFA's monitoring program with the NCQA's accreditation program for a limited number of quality standards. The report should be more comprehensive in its comparison of HCFA and NCQA's quality standards.

Major Contributors to This Report

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Appendix IV
Major Contributors to This Report

Related GAO Products

Medicare: Opportunities Are Available to Apply Managed Care Strategies
(GAO/HEHS-T-95-81, Feb. 10, 1995).

Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems (GAO/HEHS-95-1, Oct. 3, 1994).

Health Care Reform: “Report Cards” Are Useful But Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

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

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991).

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

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 22, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare’s Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

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