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Medicare: Management of the
Risk-Based HMO Program

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Committee on Ways and Means
House of Representatives



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SUMMARY

There are some widely acknowledged limitations in the present method used by the Health Care Financing Administration (HCFA) for calculating health maintenance organizations' (HMO) payment rates. HMOs tend to enroll healthier-than-average persons, according to GAO studies and others. To the degree this occurs, overcompensation results because payment calculations do not adequately account for the variations in Medicare enrollee health status. The Adjusted Community Rate process is a statutory safeguard intended to help assure that if the payment rates overcompensate HMOs, the Medicare program and/or its beneficiaries gain through either reductions in the payment rates or the provision of additional services. But HCFA's oversight and enforcement of its ACR requirements are not sufficient to assure this is occurring.

HCFA has tightened up its oversight of the HMO program considerably since May 1987, when International Medical Centers, which at the time was Medicare's largest HMO contractor, was found to be insolvent and placed in receivership by Florida. There are some inherent limitations in HCFA's ability to deal decisively with HMOs that have compliance problems the HMOs are either unable or unwilling to resolve in timely fashion. This suggests that it may be necessary for the Congress to provide HCFA broader discretion in using its sanction authorities.

Before the Congress grants HCFA proposed authority to contract with employer- and union-sponsored health plans on a prepaid basis nationwide, certain reimbursement and oversight issues should be addressed. HCFA must develop a new payment method and new beneficiary safeguards, as those pertaining to HMOs often do not apply to employer- and union-sponsored health plans. Before it is decided whether the proposal is workable, these methods and safeguards should be developed and tested.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Health Care Financing Administration's (HCFA) management of the Medicare HMO program. Specifically, you asked us to address the following topics: (1) the adequacy and reasonableness of the method for paying HMOs with Medicare risk contracts; (2) the adequacy of HCFA's oversight of HMOs to assure quality of care and general Medicare compliance; and (3) the issues that should be resolved before Medicare implements a nationwide initiative to contract on a prepaid basis with employer-sponsored retiree health plans, referred to as Medicare Insurance Groups (MIGs).

Medicare's current risk-based HMO program has been operational since April 1985. Since then, the numbers of both HMOs with Medicare contracts and beneficiaries enrolled have grown dramatically. Managing the growth of this initiative and maintaining oversight has been a challenge for HCFA and not without problems.

Let me summarize our position on each topic.

There are some widely acknowledged limitations in the current Adjusted Average Per Capita Cost (or AAPCC) method of paying HMOs. Available research shows that HMOs tend to enroll healthier than average persons and to the degree this occurs, overcompensation results. The Adjusted Community Rate (or ACR) process is a statutory safeguard intended to help assure that if the AAPCC rates overcompensate HMOs, the Medicare program and/or its beneficiaries gain either through reductions in the rates or the

provision of additional services to beneficiaries. But, our ongoing review of the ACR process is showing HCFA's oversight and enforcement of ACR requirements are not sufficient to assure this is occurring.

HCFA has tightened up its oversight of the HMO program considerably since May 1987, when International Medical Centers (IMC), a south Florida HMO, was found by the State to be insolvent and placed in receivership. Our ongoing review of HCFA's oversight, however, is showing that in many cases where HMOs are unable or unwilling to resolve compliance problems in a timely fashion, HCFA's only alternatives are to terminate the contract or tolerate continued noncompliance. This suggests it may be necessary for the Congress to provide HCFA broader discretion in using its sanction authorities.

In our recent report on HHS's MIG proposal,¹ we point out that HCFA needs to develop a new payment method and new beneficiary safeguards, as those pertaining to HMOs often cannot be applied. HCFA should demonstrate that it has adequately tested such new features before decisions are made to implement this program nationwide.

Let me now discuss these topics in more depth.

AAPCC DOES NOT ADEQUATELY
ADJUST FOR ENROLLEE HEALTH STATUS

Available research shows that the AAPCC is a poor predictor of what enrollees would cost Medicare under the fee-for-service

¹Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 2, 1987).

system. The adjusters used by the AAPCC computation process explain less than 1 percent of the variance in per beneficiary Medicare costs and, moreover, research indicates that at most, better adjusters will account for 20 percent of this variance. Furthermore, available research shows that a primary premise of using the AAPCC to set HMO rates, that HMOs enroll a cross section of Medicare beneficiaries, is not currently valid. The body of evidence is that HMOs enroll beneficiaries who are healthier on average than fee-for-service beneficiaries. This "favorable selection" in turn means that the AAPCC method overcompensates HMOs for the beneficiaries actually enrolled.

The ACR process is supposed to assure that, to the extent that the AAPCC method results in overcompensation, the Medicare program and/or its beneficiaries gain rather than the HMO. This is supposed to result from limiting HMO profits to the rate of return on their non-Medicare enrollees and plowing back any excess as additional benefits or returning the excess to Medicare. Our ongoing work indicates that HCFA has not effectively used the ACR process to accomplish this objective.

Specifically, the process is subject to HMO manipulation and error because HCFA has not enforced its requirements that an HMO (1) use its historic cost and utilization data as a basis for forecasting its ACR; and, (2) follow the prescribed methods of computing the ACR.

Our work is still under way, and we expect to have a report

this spring that will recommend ways HCFA can improve its oversight of the ACR process.

HCFA OVERSIGHT OF THE HMO PROGRAM

We also expect to issue our report this spring on HCFA's oversight of the HMO program. Our work is showing that (1) HCFA has very limited data with which to centrally monitor HMOs' quality of care, although the situation is improving; (2) HCFA's staffing for monitoring has increased, though less so than the growth of HMOs; and (3) HCFA's processes for assuring HMOs' compliance with federal requirements have not been very effective in dealing with HMOs that are either unwilling or unable to meet requirements.

Adequacy of Data

Because the contractor HMOs, and not Medicare, pay providers, HCFA has no data on individual HMO members' use of physician or outpatient services and only limited (and incomplete) data on inpatient services. The absence of such data means that HCFA cannot screen its files, as it can in the regular Medicare program, to identify providers having aberrant utilization or charge patterns. The data HCFA does receive is that needed to monitor HMOs' compliance with federal financial solvency requirements (e.g., balance sheet and income data) and to calculate HMO payments (primarily enrollment data).

While the data HCFA obtains from HMOs is too limited to do the types of provider analysis possible with its data bases on fee-for-service claims payments, HCFA could make better use of the

HMO data for program monitoring. Calculating HMO disenrollment rates, for example, is one area with potential for doing so.

High disenrollment rates can indicate potential problems in several areas such as misleading advertising and beneficiaries' problems in gaining access to care. HCFA does not produce disenrollment statistics for monitoring HMOs, although they can be produced from HCFA's databases. Using these databases, we found that about one out of six people, or 16 percent, enrolling in 95 risk-based HMOs (between July 1985 and June 1986) terminated their enrollment within 1 year of enrolling. The variation in disenrollment rates was substantial, ranging from an average of about 3.5 percent for the 10 HMOs having the lowest rates, to about 36 percent for the 10 having the highest rates. It is important that HCFA look at HMOs with relatively high disenrollment rates, as we have observed that HMOs having compliance problems also often had high disenrollments in relation to other HMOs.

In mid-1987, HCFA initiated two programs that should increase its ability to monitor HMO quality. These programs are an HMO peer review program, and a system for tracking beneficiary and provider complaints against HMOs. Prior to these efforts, HCFA did not look systematically at the care being provided to HMO members nor effectively use complaints to identify potential problems. It is too early to assess the effectiveness of either effort. Some problems, however, are being encountered by peer review organizations in obtaining enough data to draw a

statistically valid sample of cases to review. Aware of this start-up problem, HCFA has formed a study group composed of its operating components to determine how best to correct it.

HCFA Staffing Lags HMO Growth

Although the number of risk-based HMOs and Medicare enrollees increased substantially since 1985, HCFA's staff for monitoring them, while increasing, has not kept pace. Also, HCFA officials have expressed concern over the need to focus staff on resolving problems of a few HMOs such as IMC, instead of routinely monitoring all HMOs to help forestall problems. This reactive tendency can be seen in HCFA's central office site visits to HMOs during the program's first 27 months, when over half of all visits to HMOs were to IMC.

To remedy this situation, HCFA began implementing new monitoring procedures in July 1987 that require each HMO to be reviewed at least every 2 years. HCFA expects this will help it identify and resolve problems early. Whether this is so will depend on the extent and nature of problems disclosed by the new monitoring system and the two additional data gathering and review efforts just discussed. In any event, HCFA believes additional staff will be needed to monitor HMO activities.

Compliance Process Limited--Broader Authorities Needed

When HMOs are willing and able to correct identified compliance problems, resolution is generally timely. A few HMOs, however, have had recurring compliance problems or were either unresponsive or untimely in responding to HCFA's requests for

corrective action. Three HMOs we selected as case studies provided examples of compliance problems involving financial solvency, marketing practices, and--in the IMC case--various issues related to financing, quality of care, and management.

It can take a number of years for an HMO's compliance problems to become resolved, our case studies show, and over this period the HMO is often free to continue enrolling beneficiaries. Ironically, an increasing Medicare enrollment in an HMO can itself become a reason for HCFA not to terminate a contract where problems persist. For example, in the face of continuous compliance problems but fearing adverse effects of termination, HCFA permitted IMC to grow from about 5,000 Medicare enrollees in 1981 to over 135,000 before capping Medicare enrollment in 1986.

In each of the cases studied, HCFA chose instead of termination to continue working with the HMO. This is the preferred course of action when there is prompt and significant progress toward compliance--but not, in our opinion, when such progress is absent.

During the early phases of the HMO program, HCFA could do little with a noncompliant HMO short of terminating its contract. Legislation in 1986 and most recently in December 1987 broadened HCFA's sanction authority by allowing it to suspend new Medicare enrollments for such practices as submitting inaccurate data to HCFA. But this sanction cannot be applied to all the problems identified in the cases we reviewed. Among noncompliance problems

for which HCFA still cannot suspend enrollment are those involving fiscal soundness, and certain marketing and enrollment practices.

Given the diverse nature of compliance problems we identified, it may be necessary for the Congress to consider giving HCFA broader discretion to use the sanction of suspending Medicare enrollments. Such authority could be useful in dealing with HMOs that--for whatever reason--fail to make substantial, lasting progress toward meeting a Medicare requirement.

UNCERTAINTIES SURROUND MIG PROPOSAL

In our report on the MIG proposal we proposed that the Subcommittee not give blanket authority to contract with MIGs until HCFA can demonstrate that the MIG rate-setting methods and beneficiary and program safeguards are reasonable and adequate.

Our call for caution in this program stems from two factors: (1) in the past, HHS has experienced problems with new initiatives that exhibited rapid growth, which the MIG program has the potential to do; and (2) capitation of organizations that are neither providers of services nor commercial insurers is an untested concept requiring development of new reimbursement methods and beneficiary and program safeguards.

Need to Demonstrate Reimbursement Methods

The methods HCFA is considering for reimbursing MIGs vary significantly from those it uses to reimburse risk-based HMOs. There should be reasonable assurance that the payment rates under this new method do not exceed what Medicare otherwise would pay if

this group of beneficiaries remained in the fee-for-service sector.

HCFA's AAPCC methodology cannot be directly used for employer-based plans because Medicare retirees enrolled in such plans may have different health care costs than Medicare beneficiaries in general. Consequently, HCFA plans to develop a payment method based on Medicare's fee-for-service experience for the plans' retiree beneficiaries. While it is possible to set initial rates on this basis by using Medicare claims files, updating the rates in subsequent years can become a problem. This is because once an employer-based plan enters the program, HCFA will no longer process its Medicare retirees' claims and will therefore not have fee-for-service data with which to compare the rates. As time passes, therefore, it will become increasingly difficult to measure objectively whether under- or over-compensation to MIGs is occurring.

Also, HCFA's ACR method would not apply to MIGs because the ACR is based on a provider's commercial rates and MIGs, being neither commercial insurers nor providers, do not have commercial rates. Including an ACR-like component in the MIG rate-setting method is particularly important because it is through this means that HCFA can assure that beneficiaries receive a reasonable level of health care coverage for the payments made.

Need to Demonstrate
Effectiveness of Safeguards

As with any mechanism for delivering prepaid health care, the MIG program needs safeguards to help ensure that the risk-bearing

organizations have the administrative systems, financial capacity, and minimum enrollment necessary to assume risks and provide quality care. Existing key legislative safeguards for HMOs may not be effective for MIGs. This is because the safeguards are based on the presumption that the organization seeking a Medicare contract is a health care provider already established in the business of providing capitated health care services to commercial clients--presumptions not valid for most employer-based plans.

Additionally, existing statutory safeguards apply only to the organization contracting with HCFA--not its subcontractor. In our July 1986 report on the HMO demonstrations,² we found that the effectiveness of existing safeguards can be limited in those HMOs, such as IMC, which pass on much of the risk of enrollee health care costs to subcontractors. To the extent that MIGs elect to provide services through risk-bearing subcontractors, a situation can arise where such subcontractors function as HMOs without having to meet any of the federal and state financial and quality-of-care requirements normally imposed on these entities.

Given the uncertainties about payment methods and the applicability of existing safeguards for the program and its beneficiaries, we believe the best approach to the MIG program is the one provided by the Congress in the 1987 Omnibus Budget Reconciliation Act. That is, proceeding with caution by authorizing HCFA to fund a limited number of demonstration

²Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations, (GAO/HRD-86-97, July 16, 1986).

projects. HCFA plans to enter its first MIG contract this summer with the Amalgamated Life Insurance Company and is authorized to contract with up to two additional groups.

This concludes my prepared testimony. I would be happy to answer any questions you may have.