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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable Lawrence J. Smith House Of Representatives

Problems In Administering Medicare's Health Maintenance Organization Demonstration Projects In Florida

In February 1985, the Department of Health and Human Services initiated a program to expand the use of health maintenance organizations (HMOs) by Medicare beneficiaries. This new program was preceded by 26 demonstration projects throughout the country to test HMOs' effectiveness. Four of the demonstration projects, involving about half of all Medicare beneficiaries in such projects, were started in south Florida. Because of beneficiary complaints and concerns regarding those HMOs, GAO was asked to review them.

GAO found the system for coordinating HMO and Medicare payments to physicians and hospitals susceptible to errors, such as Medicare paying for services that an HMO had already been paid for. Many errors GAO identified occurred because beneficiary HMO enrollment dates were not recorded until after the actions became effective. This led to incorrect determinations as to who should pay medical expenses--the HMO or the regular Medicare program. GAO recommends that HHS correct problems resulting in erroneous payments because of the program's expansion nationwide.

GAO also identified a relatively small number of beneficiaries for whom reimbursement of medical expenses was uncertain because they were transitioning in or out of HMOs. During such periods, it is not always clear who is responsible for paying medical expenses--the beneficiary, the HMO, or Medicare. GAO is continuing to assess the magnitude and specific causes of the transitioning problems. In a follow-on report, GAO will address this and the remaining questions it was asked to pursue.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-217802

The Honorable Lawrence J. Smith
House of Representatives

Dear Mr. Smith:

This interim report responds to your January 30, 1984, request that we review four health maintenance organizations operating under contracts with the Health Care Financing Administration as demonstration projects in Florida. This review is being made to respond to a number of questions arising from beneficiary inquiries and complaints received by your office.

As agreed with your office, unless you publicly announce the report's contents earlier, no further distribution will be made until 7 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
LAWRENCE J. SMITH
HOUSE OF REPRESENTATIVES

PROBLEMS IN ADMINISTERING MEDICARE'S HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION PROJECTS IN FLORIDA

D I G E S T

In 1982 and 1983 the Department of Health and Human Services (HHS) awarded demonstration contracts to 26 organizations to develop health maintenance organizations (HMOs) for Medicare beneficiaries in 21 cities across the country. Four of the 26 HMO demonstration projects started in the Miami, Florida, area. As of October 1984 these four projects enrolled about 112,000 Medicare beneficiaries. This report focuses on selected administrative aspects of these four projects.

In February 1985 HHS initiated a nationwide program providing for the expanded use of HMOs by Medicare. Unlike most previous Medicare arrangements with HMO-type organizations, these demonstrations and the HMOs that will be created under the nationwide program (1) put the HMOs "at-risk" by paying them fixed amounts based on the average Medicare costs for all beneficiaries in the HMOs' service areas and (2) required that except for "emergency or urgently needed services," all health care for beneficiaries that enrolled must be provided or authorized by the HMOs. This latter feature is referred to as the "lock-in" provision, and any related services obtained by beneficiaries without the HMOs' authorization are referred to as "out-of-plan."

Neither the HMOs nor the regular Medicare program is supposed to pay for out-of-plan services. Beneficiaries are liable for associated costs.

In January 1984, Representative Lawrence J. Smith requested GAO to review the operations of the Florida HMO demonstration projects. The request was in response to beneficiary inquiries and complaints concerning the HMOs. Later, other members of the Florida congressional delegation also asked GAO to review the HMOs.

As GAO's work progressed, it learned that most complaints and concerns focused on (1) the timely recording of the enrollment and disenrollment of Medicare beneficiaries in the HMOs and (2) the administration of the lock-in features of the HMO projects. Therefore, GAO agreed with Representative Smith's office to provide an interim report addressing these issues.

GAO found that most beneficiaries appear to understand the HMO lock-in provisions and the need to obtain prior authorization for nonemergency medical services outside of the HMOs to which they belong. However, the system for coordinating the HMOs' operations with Medicare's administrative structure, particularly during beneficiary enrollment periods, is vulnerable to duplicate or other erroneous payments to the HMOs, hospitals, physicians, or beneficiaries.

NUMBER OF BENEFICIARIES RECEIVING OUT-OF-PLAN SERVICES

GAO determined that 6,737 Medicare beneficiaries, or 6.4 percent of the 105,000 beneficiaries it compared with the payment files of the regular Medicare program, had potentially received some out-of-plan physicians' services while they were members of the four HMOs. The total potential out-of-plan charges were about $2.6 million. In accordance with the lock-in provision, Medicare should deny (not pay) these claims. Based on all the claims that were denied, about half the beneficiaries had obtained out-of-plan services of $100 or less, and about 9 percent had obtained out-of-plan services of over $1,000.

Sixty-four people had obtained potential out-of-plan services of over $5,000. GAO's analysis of the denied claims of these beneficiaries showed that the beneficiaries had paid about 14 percent and the HMOs paid about 53 percent because (1) the services had been authorized by them and the doctors had sent the claim to Medicare by mistake or (2) when the HMOs learned of the circumstances of the denials, they decided to pay the claims. The doctors had not been paid for 22 percent, and status of the remaining 11 percent was not known. (See p. 12.)

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Of the $2.6 million in billed charges for out-of-plan physicians' services at the four HMOs, the regular Medicare program correctly denied $1.9 million and incorrectly processed for payment $700,000, or about 29 percent. The $700,000 represents "duplicate" payments because the costs of the services were included in the payment rates to the HMOs. (See p. 10.)

Also, GAO's analysis of the claims for the 64 beneficiaries showed that there was a coordination problem involving the HMOs and regular Medicare in handling denied claims. The Medicare paying agent is supposed to transfer such denied claims to the HMOs so that the HMOs can review and consider paying them if they were for authorized services or if the beneficiary was not at fault. However, GAO could locate claims for only 60 percent of the billed charges at the four HMOs. Thus, to the extent the remaining claims were not submitted to the HMO, the HMO could not act on them. (See p. 13.)

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

GAO's analysis of the hospital bills applicable to the 64 enrollees with denied physician claims of over $5,000 indicated that HHS' internal controls for coordinating the HMOs' hospital-related services with the regular Medicare program were highly vulnerable to error. In about one-fifth of the hospital admissions GAO reviewed, HHS had not advised its paying agent (a Medicare claims paying contractor, in this instance Blue Cross) that the beneficiaries were enrolled in an HMO. As a result, various hospital-related payment errors occurred.

One apparent cause of the incorrect enrollment information was the lag times between the effective dates of enrollment and when the enrollment date was recorded in the HHS information system. To test whether this problem could be widespread among Medicare HMO enrollees in Florida, GAO compared the lag times for the 13 months from January 1984 through January 1985. GAO found that the enrollment information was recorded

from 16 to 37 days after the effective enrollment dates so that any information HHS provided to its paying agents during these lag times was likely to be incorrect. (See p. 18.)

Incorrect enrollment information was one cause for errors. But the complexity of the coordination system involving HHS, the Medicare paying agents, the HMOs, and hospitals made it impractical for GAO to identify the causes of all the errors. The errors, however, have contributed to the following undesirable situations.

--Hospital bills were incorrectly paid, but the related bills for physicians' services were correctly denied, which could cause beneficiary confusion concerning the lock-in provision.

--The costs of hospital services authorized by the HMOs were not correctly charged to them, resulting in program overpayments.

--The cost of hospital services not authorized by the HMOs were charged to them, which resulted in underpayments to the HMOs or Medicare payments for noncovered services.

--HMOs did not pay beneficiaries' Medicare deductible and coinsurance charges for authorized services as provided under the HMOs' benefits. (See p. 21.)

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

GAO also identified two other problems associated with the lock-in provisions and the enrollment and disenrollment procedures where individual beneficiaries appeared vulnerable to thousands of dollars of costs for out-of-plan services. These problems relate to situations in which beneficiaries have obtained out-of-plan services during the "waiting periods" before their effective enrollment dates and after they had requested disenrollment. (See p. 25.) Essentially, during such waiting periods it is not always clear who is responsible for paying medical expenses, and in some cases beneficiaries may be liable for the full cost of medical care.

CASE STUDIES

Although GAO believes that the Congress and the beneficiaries need to know about the system's coordination problems, GAO also believes it is important for all parties to understand how these problems in the enrollment and disenrollment process and the administration of the lock-in feature of the HMO demonstration projects have affected individuals. Therefore, GAO has included case studies of 14 beneficiaries to illustrate the five problem areas discussed in the report. (See p. 32.)

CONCLUSIONS

GAO believes that the system for coordinating the HMOs' operations with the administrative structure for paying hospitals and physicians under the regular Medicare program is vulnerable to error. As shown in the case studies, not only are payment errors costly and disruptive to the program and providers, but they can also affect beneficiaries. In view of this and the fact that the HMO program may expand rapidly under the regulations that became effective in February 1985, GAO believes HHS should direct the Health Care Financing Administration (HCFA) to correct the problems leading to the incorrect payments. This would help prevent similar problems from arising as new HMOs enter the program.

GAO believes that individual beneficiaries are most vulnerable to significant costs of out-of-plan services during the waiting period before their enrollment and after their disenrollment. GAO found, however, that the beneficiaries, their families, or others had actually paid a relatively small portion (14 percent) of the charges for such services. Nevertheless, when individuals incur expenses involving thousands of dollars which may not be paid by either the HMO or the regular Medicare program, it could be a traumatic experience. GAO is continuing to assess the magnitude and specific causes of the problems experienced by beneficiaries entering and leaving HMOs. GAO's final report will address any necessary corrective actions.

RECOMMENDATIONS

The Secretary of HHS should direct the Administrator of HCFA to act to identify and correct the systemic problems leading to the erroneous physician and hospital payments GAO found. Corrective action should center on overcoming the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and problems with the computerized exchange of data among the Medicare paying agents, HMOs, and HCFA.

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GAO did not obtain comments on the report from HHS, the Medicare paying agents, or the individual HMOs discussed. However, the problems identified were discussed with HHS and paying agent officials.

Contents

ABBREVIATIONS

AAPCC	adjusted average per capita costs
AV-MED	AV-MED Inc.
CAC	CAC Health Plans, Inc.
GAO	General Accounting Office
GPPP	Group Practice Prepayment Plan
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IMC	International Medical Center
OMB	Office of Management and Budget
SSA	Social Security Administration
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

CHAPTER 1

INTRODUCTION

The Medicare program, which began on July 1, 1966, was authorized by the Social Security Amendments of 1965, which added title XVIII of the Social Security Act (42 U.S.C. 1395). Medicare pays for much of the health care costs for eligible persons age 65 or older. In 1972, Medicare was extended to provide protection to certain disabled persons and to individuals suffering from kidney (renal) failure. The program is administered by the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS).

Medicare provides two forms of protection. Medicare part A--Hospital Insurance for the Aged and Disabled--covers services furnished by institutional providers, primarily hospitals, home health agencies, and after a hospital stay, skilled nursing facilities. Inpatient care is subject to various deductible and coinsurance amounts. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. During fiscal year 1984, about 30 million people were eligible for part A benefits, and benefit payments were about $41.5 billion.

Medicare part B--Supplementary Medical Insurance for the Aged and Disabled--covers (1) physicians' services, (2) outpatient hospital care, and (3) other medical and health services. This insurance generally covers 80 percent of the reasonable charges for these services subject to an annual $75 deductible. Enrollment in part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and by appropriations from general revenues. During fiscal year 1984, an average of 28.7 million people were enrolled, and part B benefit payments were about $19.5 billion, of which about 25 percent was financed by enrollees' premiums and about 75 percent by appropriations.

HCFA administers Medicare through a network of contractors, such as Blue Cross and Blue Shield, to process Medicare claims and to make payments on behalf of the government. The contractors that pay institutional providers, such as hospitals and nursing homes, are referred to as part A intermediaries; the contractors that pay for the services of noninstitutional providers, such as doctors, laboratories, and suppliers, are called part B carriers.

HMOS AND MEDICARE

Section 1833 of the original Medicare law included provisions for reimbursing, on a reasonable charge or reasonable cost

basis, group practice prepayment plans (GPPPs) for part B services provided to Medicare eligibles enrolled in such plans. According to HCFA statistics, in June 1984 44 GPPPs were participating in Medicare with about 575,000 Medicare-eligible members. Medicare pays for services received by GPPP members from providers and practitioners who are not affiliated with the GPPP.

The Social Security Amendments of 1972 (Public Law 92-603) added to the law section 1876, which sets forth the conditions under which health maintenance organizations (HMOs) could contract with Medicare. Essentially, section 1876 gave HMOs the option to enter into cost-based or risk-based contracts. Under cost-based contracts, HMOs function similarly to GPPPs except that payments may include the costs of both part A and part B covered services. Also, like the GPPPs, Medicare members can use and receive reimbursement for out-of-plan services.

Section 1876 risk-contract HMOs are also paid on the basis of their costs of providing parts A and B services. However, the HMO's allowed costs per member are compared to the "adjusted average per capita cost" (AAPCC) for all Medicare beneficiaries in the HMO's service area, and if the HMO costs are higher than the AAPCC, the HMO must absorb the loss or carry it over to be offset with future "savings." If the HMO's costs are less than the AAPCC, it shares the savings with Medicare on a 50-50 basis. The HMO's share, however, is limited to 10 percent of the AAPCC. Under risk-type contracts, Medicare enrollees are subject to the "lock-in" feature, which generally provides that except for "emergency and urgently needed services," all health care for enrolled beneficiaries must be provided by or authorized by the HMOs.

Section 114 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (Public Law 97-248) amended section 1876 of the Social Security Act to encourage more risk-based contracts by providing for fixed per patient payment rates of 95 percent of the AAPCC. Instead of sharing any savings with Medicare, section 1876 provides that the savings must be used to provide Medicare members with additional health benefits or reduced cost sharing.[1] The Congress was concerned that the adjustments being made under the methodology used at that time to compute the AAPCC did not adequately reflect the relative health care needs (i.e., disability status and other characteristics) of Medicare beneficiaries who

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[1]Under the four Florida HMO demonstration projects discussed throughout this report, the beneficiaries are not liable for any deductibles or coinsurance amounts as they would be under the regular Medicare program.

enroll in the HMOs as compared to beneficiaries in the regular Medicare fee-for-service system. Thus, payment rates would either be too high or too low depending on whether HMOs attracted relatively more or less healthy beneficiaries. Therefore, the effective date of implementing the HMO amendments made by TEFRA was established as the latter of (1) October 1, 1983, or (2) when the Secretary of HHS notified the cognizant congressional committees that she is "reasonably certain" that an appropriate methodology for computing the AAPCC to assure actuarial equivalence of HMO and non-HMO members had been developed. In May 1984, the proposed regulations to implement section 114 of TEFRA were published. In January 1985, the final regulations were issued to be effective February 1, 1985. The Secretary provided the required notification to the congressional committees on January 7, 1985.

The demonstration projects

In 1982 and 1983, HCFA awarded contracts under its demonstration authority to 26 organizations to develop Medicare competitive health care systems or HMOs. Such demonstration projects became operational in 21 cities across the country. In some cases an organization operated in more than one locality. Like the TEFRA amendment, the per patient payment rates are fixed at 95 percent of the AAPCC. As of October 1, 1984, there were about 219,000 Medicare enrollees in the operational demonstration projects nationwide. In contrast to the operational demonstration projects, 63 HMOs with about 130,000 Medicare members had section 1876 contracts as of June 1984. Of these, 62 had cost contracts and 1 was under a risk contract.

This report deals with four HMO demonstration projects that started in the Miami, Florida, area. These projects had about 112,000 Medicare enrollees on October 1, 1984. The four HMO demonstration projects, the dates they began, their total Medicare enrollment as of December 1, 1984, and Medicare payments to the HMOs as of December 1, 1984, are shown in the following table.

HMO	Inception of projects	Number of Medicare enrollees (Dec. 1, 1984)	Medicare payments through Dec. 1, 1984
			(000 omitted)
International Medical Centers, Inc.	8/1/82	104,090	$273,512
AV-MED Inc.	11/1/82	10,254	26,816
CAC Health Plans, Inc.	10/1/82	4,894	21,429
Health Care of Broward	2/1/83	2,636	9,633
Total		121,874	$331,390[a]

[a]Includes $43,857,000 withheld by HCFA to pay, on the HMOs' behalf, hospital bills for International Medical Centers, AV-MED, and Health Care of Broward.

Source: HCFA.

OBJECTIVES, SCOPE, AND METHODOLOGY

On January 30, 1984, Representative Lawrence J. Smith requested that we review the operations of the four HCFA HMO demonstration projects in south Florida. This request was in response to beneficiary inquiries and complaints received by his office. Later other members of the Florida congressional delegation also asked us to review these HMOs.

As our work progressed, we learned that most beneficiary complaints and concerns identified during our review of HCFA files as well as from inquiries received from the Congressman's office and from other members of the Florida delegation related to (1) the timely recording of beneficiaries' enrollment in and disenrollment from the HMOs (which we call transitioning); (2) the administration of the "lock-in" feature of the HMO projects, which provides that payment will not be made by the HMO or by the regular Medicare program for services provided by institutions or practitioners not affiliated with the HMO unless such services are "emergency services" or "urgently needed services" outside the HMO's service area; and (3) the extent of

beneficiary liability for services provided outside the HMO whether provided on an "emergency" or other basis.[2]

Because of these concerns, we agreed with Representative Smith's office to provide an interim report to primarily focus on the above problems. More detailed information on those problems and other questions to be addressed in the final report will include:

--HMOs' methods of marketing and enrollment.

--Actions being taken to assure that quality care is provided.

--HMOs' contracting arrangements with health care providers, such as hospitals and medical specialists.

--The reasonableness of Medicare HMO payment rates.

Our principal objectives in this phase of our work were to determine

--the number of Medicare beneficiaries who had received out-of-plan services during the period they were enrolled in the HMOs;

--the value of such services expressed in terms of billed charges or, in the case of paid hospital bills, the reimbursed amount;

--whether such charges were denied or correctly/incorrectly paid by the Medicare paying agents (intermediaries and carriers); and

--whether the HMOs assumed financial responsibility for out-of-plan services provided to their members, the beneficiaries or their families were required to pay for such services, or the providers of service had absorbed the revenue losses.

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[2]According to unofficial HCFA statistics, of the 629 complaints involving the four HMOs that were received from various sources from May 1, 1983, through June 30, 1984, about 92 percent pertained to enrollment and disenrollment practices, and 4 percent involved the nonpayment of medical bills and the failure to explain the HMO "lock-in" feature. The other 4 percent appeared to primarily involve quality of care issues.

Another objective was to determine whether the procedures for recording enrollments and disenrollments on HCFA's records contributed to beneficiaries obtaining out-of-plan services or to the Medicare paying agents making incorrect payments.

The HMOs provided us computer tapes identifying each Medicare beneficiary who had enrolled from the project's initiation date through February 28, 1984, and the time periods that these individuals were enrolled. We then matched these individuals and related enrollment data to the payment history records of the principal Medicare carrier in Florida responsible for paying doctor bills (Florida Blue Shield) to determine how many claims it had received for these beneficiaries while they were HMO members and whether the claims had been paid or denied. We eliminated those denials that were identified as "duplicates"--that is, denied more than once--on the payment history tapes. The carrier's payment history tapes included data on the "place of service," including inpatient and outpatient hospital data; we used this information to identify individuals who should have had related hospital bills. For those individuals, we asked the principal intermediary in Florida responsible for paying hospital bills (Florida Blue Cross) for comparable payment and denial information.

From the computer matches for Florida Blue Shield, we arrayed the denied charges by individual to determine the amount of services each had received that were potentially out-of-plan. For those 64 enrollees that the initial computer analysis showed had more than $5,000 of denied doctors' claims, including claims denied more than once, we asked about each case at the applicable HMO and asked selected non-HMO providers who had furnished out-of-plan services what had occurred.

For these 64 enrollees, we analyzed Florida Blue Cross records to identify any payments made by it to hospitals while the individuals were enrolled in the HMOs. We determined whether

HCFA's query process[3] had correctly identified the individuals as HMO members and advised the intermediary and hospitals accordingly. We also wanted to determine when Blue Cross paid hospital bills on behalf of an HMO, whether such payments were shown on the HCFA bill itemization lists for deductions from the HMOs' capitation payments. There is no comparable provision for Blue Shield to pay doctors' bills on behalf of the HMOs.

As requested by Representative Smith, we did not obtain comments from HHS or the HMOs on this report. Except as noted above, our work was done in accordance with generally accepted government audit standards.

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[3]An internal control mechanism to advise the paying agents that patients are eligible for Medicare and that they have not exhausted their benefits. According to HCFA instructions, a hospital that provides hospital inpatient services to a Medicare beneficiary sends an admission notice to the intermediary (e.g., Florida Blue Cross) for all admissions, including those for HMO members. Blue Cross then queries HCFA to determine (1) the status of the beneficiary (HMO member or not) and certain other information from HCFA's Health Insurance Master File and (2) the payment option that the particular HMO had elected to use. Three of the four Florida HMOs (IMC, AV-MED, and Broward) had elected the payment option under which the intermediary processes and pays the bills on behalf of the HMOs, except for those hospitals that had agreements with the HMO for it to pay bills directly. CAC had elected the payment option to process and pay all hospital bills on behalf of its members.

For bills received by the intermediary for part B outpatient hospital services, the intermediary may query HCFA to determine the HMO status of the beneficiary and the payment option selected by the HMO, depending on whether the intermediary knew that a beneficiary's part B deductible had been satisfied. There is a similar HCFA query system for carriers under part B which is also used depending on the status of the part B deductible. Also, HCFA provides its contractors an automatic notice of changes in beneficiary status so that the paying agents can update their records to identify HMO members.

CHAPTER 2

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Overall, 6,737 Medicare beneficiaries, or 6.4 percent of the 105,000 beneficiaries we screened, had potentially received some out-of-plan part B services while they were members of one of the four HMOs.[1] This included 1,530 beneficiaries where Florida Blue Shield had paid all of the claims for out-of-plan services. Of the remaining 5,207 beneficiaries with denied claims, about 9 percent of them had denied claims exceeding $1,000, and they accounted for about 66 percent of the total gross denied charges. This indicates that the problems of out-of-plan services that result in large beneficiary liabilities involved relatively few individuals.

Based on submitted charges (that is, the amounts the doctors charged), the net value of the out-of-plan part B services was about $2.6 million, of which Florida Blue Shield (or its predecessor in south Florida) correctly denied about $1.9 million and incorrectly paid claims with submitted charges of $700,000, or about 29 percent. The amounts Blue Shield paid represent "duplicate" payments because these services were included in the HMOs' capitation or premium amounts.

In addition to the relatively high incidence of incorrect payments for out-of-plan services, we believe that there is also a coordination problem involving Florida Blue Shield and the HMOs in handling claims denied by the Medicare carrier. This problem has contributed to situations where a provider or beneficiary was not paid by the HMOs because the HMOs were not advised of the outstanding claims.

HOW PAYMENTS FOR HMO MEDICARE ENROLLEES SHOULD BE MADE

Medicare's capitation payments to HMOs are supposed to be payment for all covered services needed by enrolled beneficiaries. Therefore, once a beneficiary is enrolled in an HMO, Medicare should make no payments on his/her behalf except for the capitation payment. When the beneficiary enrolls in an HMO, he/she agrees to receive services only from providers affiliated

[1]We use the term "potentially" because during our review of individual cases, we found that the Medicare carrier had received claims for services that had been authorized by the HMOs and should have been submitted to the HMOs.

with the HMO, and if the beneficiary goes to a non-HMO provider, neither the HMO nor Medicare is obligated to pay and the beneficiary is personally liable. The only exceptions to this rule are

--when the HMO authorizes the beneficiary to go to a non-HMO provider for services,

--when the beneficiary requires emergency services, or

--when the beneficiary is not within the HMO's service area (for example, while traveling) and requires services urgently.

In these cases the HMO, but not Medicare, is liable for payment.

If a beneficiary goes to a non-HMO provider for an unauthorized, nonemergency service, he/she is personally liable for full payment. If Medicare were to pay for such a service, it would be making duplicate payments because it has already paid the HMO, through the capitation payment, for the service. In effect, unauthorized, nonemergency services for HMO enrollees from providers, other than the HMO itself, are noncovered services under Medicare.

NUMBER OF HMO MEDICARE ENROLLEES WITH OUT-OF-PLAN SERVICES

As summarized in the following table, our computer match of HMO enrollees with Florida Blue Shield part B payments showed that over 6 percent of the Medicare enrollees at the four HMOs potentially had received some out-of-plan part B services.

HMO	Period	HMO Medicare enrollees screened	Those potentially receiving out-of-plan services	
			Number	Percent of enrollees screened
IMC	8/1/82 - 2/28/84	86,257	5,321	6.2
AV-MED	11/1/82 - 2/28/84	10,547	973	9.2
CAC	10/1/82 - 2/28/84	5,176	337	6.5
Broward	2/1/83 - 2/28/84	3,087	106	3.4
Total		105,067	6,737	6.4

The data in the above table may understate the number of Medicare beneficiaries enrolled in the four HMOs who potentially received out-of-plan services. Our computer match would not identify beneficiaries who obtained out-of-plan services but did not submit a claim for them to Florida Blue Shield or who received out-of-plan services in geographic areas where the claim would have been submitted to another carrier.

Of the 6,737 HMO enrollees potentially receiving part B out-of-plan services, we identified 1,595 who had also received inpatient or outpatient hospital services.

AMOUNTS OF POTENTIAL OUT-OF-PLAN PHYSICIANS' SERVICES INCLUDE TOO MANY PAID CLAIMS

The value of part B services that were potentially out-of-plan for the 6,737 HMO Medicare enrollees expressed in terms of billed charges for the denied claims and billed and allowed charges for the paid claims is summarized in the following table.

	Number of line items[a]	Amounts	
		Billed	Allowed
Claims denied	37,122	$2,149,700	b
Less apparent duplicate denials	5,428	294,115	b
Adjusted total	31,694	1,855,585	b
Claims allowed	12,441	745,097	$562,234
Total	44,135	$2,600,682	

[a]A line item represents a specific type of service, such as an office or hospital visit each time it is claimed.

[b]Not applicable.

Of the $562,234 in allowed charges for the claims paid, Blue Shield paid about 80 percent, and the beneficiary was liable for the remaining 20-percent coinsurance and any unpaid deductible. The amounts Blue Shield paid represent "duplicate" payments because these services were included in the HMOs' capitation or premium amounts and these payments were therefore incorrect.

Compared with the total value ($2,600,682) of the part B out-of-plan services identified in our computer match, the incorrect billed amounts ($745,097) represent about 29 percent. We believe this "error" rate is too high.

We asked Florida Blue Shield for explanations of how these incorrect payments occurred for 25 beneficiaries who had allowed charges of about $30,500. The carrier told us that the erroneous payments for 9 of the 25 beneficiaries resulted because before December 1983 its claims processing system did not maintain for beneficiaries who disenrolled from an HMO a record of the beneficiaries' enrollment periods. Thus, if a claim for an out-of-plan service provided when the beneficiary was an HMO enrollee was submitted after disenrollment, the computer would not identify the claim as noncovered and it would be paid. For the other 16 beneficiaries, Florida Blue Shield said that the problem apparently lies with delays by HCFA in notifying the carrier that the beneficiary had enrolled in an HMO. The carrier said that weeks or months passed before it was notified of enrollment in an HMO. If an out-of-plan claim was submitted in the interim, the carrier would pay it because it did not know it was for a noncovered service.[2]

The beneficiary case studies in appendix II include five examples that illustrate these problems.[3] In four of the cases, Blue Shield told us that the incorrect payments were due to the problem with its computer system, and in the other case, Blue Shield told us the problem was due to the untimely updating of records by HCFA. In two of the five case studies, both Blue Shield and the HMO had paid the same doctors for the same services.

DISTRIBUTION OF AMOUNTS OF POTENTIAL OUT-OF-PLAN SERVICES

We arrayed the denied part B claims by beneficiary to develop a distribution by the amount of the denials. As shown by the following table, about half the beneficiaries had out-of-plan denied claims amounting to $100 or less which represented nearly 6 percent of the total value of potential out-of-plan services. In contrast, about 9 percent of the beneficiaries

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[2]At Blue Shield's request, we provided a listing of the claims involved with the $562,234 in erroneously allowed charges we identified in order for the carrier to request refunds from the parties paid in error.

[3]See cases of Ms. B., Ms. C., Mr. W., Mr. R., and Ms. G. in appendix II.

(482) had denials of more than $1,000. These denials represented about 66 percent of the total value of potential out-of-plan services. This indicates that the problems with the lock-in provision and out-of-plan services which result in significant beneficiary liabilities involve relatively few individuals.

Part B amounts denied	Submitted charges on part B claims denied: Number of beneficiaries	Percent	Total amounts denied	Percent	Submitted charges on part B claims allowed: Number of beneficiaries	Amount
$1 to $100	2,734	52.5	$ 124,590	5.8	624	$143,992
$101 to $500	1,656	31.8	376,841	17.5	408	158,706
$501 to $1,000	335	6.4	234,731	10.9	111	59,353
$1,001 to $5,000	418	8.0	890,985	41.4	153	107,507
Over $5,000	64	1.3	522,553	24.4	24	37,691
Subtotal	5,207	100.0	2,149,700	100.0	1,320	507,249
All out-of-plan claims paid	1,530		a		1,530	237,848
Total	6,737		$2,149,700		2,850	$745,097

[a]Not applicable.

Of the 6,737 beneficiaries with out-of-plan services, 1,320 beneficiaries had some claims denied while others were allowed and paid. In our view, this inconsistency could be confusing to beneficiaries and would not facilitate beneficiary understanding of the HMOs' lock-in provisions. According to the enrollment forms, beneficiaries are told that if they obtain services out-of-plan, other than emergency or urgently needed services, neither the HMOs nor Medicare will pay. However, if Medicare does pay in some of these instances, the beneficiaries are getting mixed signals.

BENEFICIARIES WITH MORE THAN $5,000 DENIED PART B CLAIMS

The 64 beneficiaries that the computer match showed as having total denied part B claims of over $5,000 each (including multiple denials of claims for the same service) while they were enrolled in an HMO were distributed among the four HMOs as follows.

HMO	Number of beneficiaries	Part B billed charges: Amounts denied	Part B billed charges: Amounts allowed
IMC	42	$338,902	$13,543
AV-MED	11	84,754	7,621
CAC	9	82,962	16,527
Broward	2	15,935	-
Total	64	$522,553	$37,691

We found that overall, the 64 Medicare beneficiaries, their families, or others had paid a relatively small portion (about 14 percent) of the billed charges on the unduplicated denied claims. The HMOs had paid, settled, or were reviewing about 53 percent of the charges denied by Blue Shield. Reasons why the HMO paid or settled the claims were (1) the services had been authorized by the HMO and the provider had sent the claims to Blue Shield in error and (2) when the HMOs learned of the denials and the circumstances of the out-of-plan services, they decided to accept financial responsibility for them. The providers had not been paid for 22 percent of the total denied charges. The status of the remaining 11 percent of the denied charges either is unknown or will probably be paid by the regular Medicare program because the beneficiary was "retroactively" disenrolled to his/her initial enrollment date.

A summary of the disposition of the denied claims for the 64 beneficiaries for each of the four HMOs is included in appendix I.

NEED FOR BETTER EXCHANGE OF INFORMATION ON DENIED CLAIMS

According to HCFA instructions, when Florida Blue Shield denies a claim because it involves an HMO member, it should transfer the claim to the HMO. We believe that compliance with this instruction is important for two reasons. First, the HMO may have authorized the services or the services may have been provided under circumstances where the beneficiary was without fault and the HMO might settle the claim it received. Second, if the HMOs do not receive the denied claims, they have difficulty identifying enrollees who are getting services out-of-plan and providing these individuals with appropriate education and guidance on the lock-in provision.

For the 64 beneficiaries with denied claims of over $5,000, we were not able to locate the claims for about 40 percent of the billed charges at the four HMOs we visited. This means that

either Blue Shield had not transferred the denied claims to the HMO as it was supposed to or the claims were transferred and the HMOs had lost them. Based on the HMOs' correspondence controls, we believe that the former was the case.

Eight of the case studies in appendix II illustrate this problem.[4] In seven of the eight cases we believe that there was an adverse effect on beneficiaries or providers because the HMOs probably would have paid the claims if they had received them. In these cases, either (1) the claims were in connection with hospital admissions that the HMOs had authorized and they had paid other related doctors' bills or (2) the beneficiaries were not at fault. In one case (Mr. F.) a beneficiary was in the hospital on the effective date of his enrollment and he or his wife had paid $5,757 in doctors' bills denied by Blue Shield for related physicians' services provided after the effective date. We could not locate Mr. F.'s denied claims at the HMO. The remaining case study (Ms. Z.) involves a situation where the HMO had denied all the Blue Shield-denied claims for this beneficiary that we located at the HMO.

CONCLUSION

A large majority of the beneficiaries enrolled in the four Florida demonstration projects appeared to have understood the lock-in provision. Only about 6 percent of the beneficiaries compared against the Blue Shield claims history files had obtained some out-of-plan part B services while they were enrolled. In terms of denied claims for out-of-plan services, the distribution is highly skewed in that of 5,207 beneficiaries with submitted charges on part B claims denied, 482 accounted for nearly 66 percent of the total denied charges. Blue Shield had incorrectly paid about 80 percent of the $562,234 in allowed charges for the claims paid. We believe that there is a need for better coordination between the Medicare part B carrier and the HMOs in handling denied claims.

In summary, we believe that the system for coordinating the HMOs' operations with the administrative structure for paying for physicians' services under the regular Medicare program is vulnerable to error. In view of the fact that HMO programs to serve Medicare beneficiaries may expand rapidly under the January 1985 regulations implementing section 114 of TEFRA, we believe that HCFA should correct the problems leading to the incorrect payments discussed in this chapter. This would help prevent similar problems from arising elsewhere when additional HMOs join the program. The recommendation we make in chapter 3 would also address the payment problems discussed in this chapter.

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[4]See cases of Mr. C. S., Mr. F., Ms. R., Ms. Z., Mr. W., Ms. G, Mr. M., and Ms. T. in appendix II.

CHAPTER 3

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

Our analysis of the hospital bills applicable to the 64 enrollees with denied part B claims over $5,000 showed that there were a series of coordination problems involving three of the four HMOs, hospitals, Florida Blue Cross, and HCFA regarding inpatient and outpatient hospital services provided to HMO members. A lack of communication or erroneous communications among them were resulting in erroneous payment of claims and delays in making payments. The coordination problems have contributed to the following undesirable situations:

--Hospital bills were erroneously paid by the intermediary, whereas the related inpatient claims for physicians (part B) services were correctly denied by the carrier. This could cause beneficiary confusion concerning the lock-in provision.

--The cost of hospital services that were authorized by the HMOs were not correctly charged to them, which would result in Medicare overpayments to the HMOs.

--The cost of services not authorized by HMOs were charged to them without a determination that they were "emergency" services, which would result in underpayments to the HMOs.

--HMOs did not pay beneficiaries' deductible and coinsurance charges for authorized services as they were supposed to do, principally because Blue Cross had not notified the HMOs of the payments made on their behalf.

--Hospitals could be misled or confused because the intermediary had not advised them that patients were enrolled in an HMO.

Although the beneficiary cases that we studied were not typical because of their high use of health services, we believe that the coordination problems identified are systemic and, thus, could occur for other HMO members using hospital services. This is especially true shortly after their enrollment, when it is important that all parties know a beneficiary is in an HMO so claims can be properly processed.

To test this hypothesis, we analyzed the time lags between the effective dates of enrollment for all HMO members in south

Florida and the dates the information was recorded in the HCFA file used to respond to hospital admission notices. This analysis showed that for the 13 months from January 1984 through January 1985, the information was recorded from 16 to 37 days after the effective enrollment dates. (See p. 18.) Therefore, any hospital admission notices submitted to HCFA during these lag times would be likely to result in incorrect responses to the hospital regarding eligibility for services.

HOW THE HOSPITAL ADMISSION NOTICE PROCESS SHOULD WORK

When a Medicare beneficiary is admitted to a hospital, the hospital notifies its intermediary, which in turn asks HCFA for information on the beneficiary's eligibility for services. HCFA responds as to whether the individual is covered by Medicare, whether the inpatient deductible applies to the beneficiary, and how many days of coverage are available. This response enables the hospital to correctly charge the patient for the amount he/she is personally liable for.

If the beneficiary is enrolled in an HMO, the response to the hospital admission notice so indicates. The hospital then knows it has to seek payment from the HMO[1] and can assure that appropriate authorization is obtained from it. Thus, the accuracy of HCFA's response is important to assure correct payment for the hospital stay.

ANALYSIS OF HOSPITAL BILLS PROCESSED BY BLUE CROSS FOR MEMBERS OF IMC, AV-MED, AND BROWARD

Of the 64 beneficiaries with denied part B claims over $5,000, 55 were members of IMC, AV-MED, and Broward. These HMOs had elected to authorize the fiscal intermediaries[2] in Florida to make payments on their behalf to institutional providers, such as hospitals, that did not have a direct agreement with the HMOs. Our analysis of the "place of service" shown on part B claims indicated that all of these beneficiaries had received hospital services while they were enrolled. We identified

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[1]In some instances, Medicare will pay the hospital on behalf of the HMO and deduct the hospital payment from future payments to the HMO. In such cases the intermediary is responsible for determining if the HMO has authorized the care and notifying the hospital.

[2]There are four intermediaries serving providers in Florida. Florida Blue Cross is the principal one.

inpatient and/or outpatient hospital bills for 46 of the 55 beneficiaries that had been processed by Blue Cross for services provided while they were members of the three HMOs.

A discussion of our findings in relation to adherence with the HCFA procedures and instructions follows.

Inpatient hospital services

According to HCFA instructions, depending on HCFA's response to the hospital admission notice, the intermediaries, the HMOs, and the hospitals are supposed to do various things regarding the bills. For example, if the response shows that the beneficiary is an HMO enrollee, the intermediary should determine whether the hospital has an agreement with the HMO, in which case the hospital is instructed to send the bill to the HMO. If the hospital does not have an agreement with the HMO, the hospital is instructed to send the bill to the intermediary, and the intermediary is responsible for determining whether the admission was authorized by the HMO. If the admission was not authorized (out-of-plan), the hospital should send documentation to the intermediary on the emergency nature of the services within 3 days of the notice to the hospital so the intermediary can make a determination whether to pay the bill.

Further, the instructions provide that when the intermediary processes a bill on behalf of an HMO, it should send an information copy to the HMO. Under the Florida demonstrations, this information provides one basis for the HMO to pay any deductible and coinsurance charges on behalf of the member as is provided under their benefit structures.

If the response does not show that a beneficiary is an HMO member, the hospital is advised accordingly, and the bill should be processed as a regular Medicare claim.

When Florida Blue Cross pays a bill on behalf of an HMO (either as an authorized admission or as an "emergency"), the payment is supposed to be deducted from the HMO's capitation payments.[3] One procedure for accomplishing this is that Blue Cross submits a monthly record of all its payments to HCFA. HCFA edits the records to determine whether the beneficiary was enrolled in an HMO when the services were provided. If so, the payment is listed on a bill itemization list for each HMO which HCFA uses to calculate the deductions. One problem with this

[3]This deduction is necessary because in computing the capitation payments to the HMOs, the average cost of Medicare hospital benefits in the geographical area has been included.

procedure is that the payment information furnished by Florida Blue Cross does not show whether the bill was paid on behalf of the HMO (either as an authorized admission or an emergency), and this can result in the cost of services not authorized by the HMO being charged to it. According to HCFA officials, HCFA relies on the HMOs to identify these situations through their review of the bill itemization lists.

In 10 of the 55 members' admissions we reviewed, when Blue Cross notified HCFA of the admission, it was not correctly advised that the beneficiary was an HMO member. In 2 of the 10 cases, the incorrect HCFA response did not result in any incorrect or inconsistent payments because the bills were rejected by Blue Cross and the admission had not been authorized by the HMO.

We believe that one cause of the problems associated with the incorrect HCFA responses was delays in recording in the HCFA Health Insurance Master File the beneficiaries' enrollment in the HMO. In all 10 cases where HCFA had supplied the intermediary with incorrect information, the admission occurred during the first month of enrollment.

To determine whether the problem of incorrect responses during the first month of enrollment would be unique to the beneficiaries we studied, we analyzed for the period January 1984 through January 1985 the time lags between the effective dates of enrollment for all Medicare HMO enrollees in south Florida and the dates the information was posted to HCFA's Health Insurance Master File.

As shown in the following table, the time lag ranged from 16 to 37 days. To the extent that HCFA received inquiries during these lag periods, HCFA would have provided incorrect responses.

Effective date	Number enrolled	Dates posted	Time lag (days)
January 1, 1984	18,086	February 4, 1984	35
February 1, 1984	22,456	February 25, 1984	25
March 1, 1984	11,888	March 16, 1984	16
April 1, 1984	9,226	April 28, 1984	28
May 1, 1984	7,986	May 16, 1984	16
June 1, 1984	9,952	July 7, 1984	37
July 1, 1984	8,098	July 25, 1984	25
August 1, 1984	6,229	August 23, 1984	23
September 1, 1984	6,925	September 27, 1984	27
October 1, 1984	7,790	November 1, 1984	32
November 1, 1984	8,023	November 24, 1984	24
December 1, 1984	7,812	December 28, 1984	28
January 1, 1985	7,126	January 18, 1985	18

Of the 55 members' admissions we reviewed, Blue Cross made payments for 44. The HMOs had a record of 22 of these payments. For the remaining 22 admissions, the related deductible and coinsurance amounts that the HMOs had not paid totaled about $7,400. We did not determine whether these underpayments were absorbed by the beneficiaries or the hospitals.

Of the 44 admissions for which payment was made, 40 were authorized by the HMO and 4 were not. We located the payments for 31 admissions on HCFA's bill itemization lists to be deducted from the HMO's payments. However, we could not find on the lists the payments for 13 admissions totaling about $74,700. Whether the admissions were authorized by the HMO or not, these payments represent potential program overpayments. If they were authorized and not deducted from the HMO's capitation payments, they represent duplicate payments. If they were not authorized, they represent payments for noncovered services. We have provided HCFA officials with a list of the payments we could not locate to see whether they could find them.

Overall, of the 44 admissions for which payments were made by Blue Cross, 17 totaling about $94,707 were correctly and consistently handled in accordance with HCFA procedures. For these 17 admissions, (1) HCFA's notification correctly showed that the beneficiaries were members of an HMO, (2) the HMO had authorized the admission, (3) the HMO had a record of the payment by Florida Blue Cross, and (4) the payment was listed on the HCFA bill itemization lists to be deducted from the HMO's capitation payments. The other 27 admissions involving payments of about $186,634 were not handled correctly in all respects. Because of the complexity of the coordination system involving HCFA, the intermediary, the HMOs, and the hospitals, it was not practical for us to identify the causes of all the errors. Our analysis of the Blue Cross payments involved in the 44 admissions is shown on the following table.

Description	Potential adverse effects[a]	Number of admissions	Amounts paid
Admissions correctly handled by HCFA, Blue Cross, and HMOs in all respects	None	17	$ 94,707
Admissions not correctly and consistently handled, HCFA response incorrect:			
Services authorized and charged to HMO with HMO having record of payment	None	1	$ 7,250
Services not authorized and not charged to HMO	1. No review to determine "emergency" 2. Medicare overpayment	1	12,118
Services authorized and charged to HMO, but HMO had no record of payment	HMO would not pay beneficiaries' deductible and coinsurance	4	21,699
Services not authorized but charged to HMO and related part B claims denied	1. No review to determine emergency 2. Medicare payment for noncovered services 3. Underpayment to HMO 4. Beneficiary confusion concerning "lock-in"	2	7,543
Subtotal		8	48,610
HCFA query response correct but:			
Services authorized and charged to HMO, but HMO had no record of payment	HMO would not pay any beneficiaries' deductible and coinsurance	7	75,484
Services authorized and not charged to HMO	Medicare overpayment	11	52,352
Services not authorized and not charged to HMO	Medicare overpayment	1	10,188
Subtotal		19	138,024
Subtotal not correctly or consistently handled		27	186,634
Total payments		44	$281,341

[a]In some cases where services were authorized but not charged to the HMO, the HMO also had no record of payment so that an additional adverse effect would be that the HMO would not pay the beneficiaries' cost sharing charges for covered services as provided for in its plan. Also to the extent that hospitals were not advised that a beneficiary was a member of an HMO due to the incorrect HCFA response to the admission notice, they could have been misled or confused.

Five of the case studies involving six admissions included in appendix II illustrate the coordination problems with the Medicare intermediary and the HCFA response to the admission notice process. For five of the six admissions, the HCFA response was incorrect and the case studies show the wide variety in the types and adverse effects of the payment errors that occurred. For example, a hospital was incorrectly paid for services not authorized by the HMO, but the costs of the services were charged to the HMO's capitation payments (Mr. V.). In another case, the admissions were authorized by the HMO but not charged to the HMO for deduction from its capitation payments (Mr. M.). In another case, the beneficiary's cost sharing amounts were not paid by the HMO (Ms. R.). In another case, the hospital was incorrectly paid for an admission not authorized by the HMO and the cost was not charged to the HMO (Mr. T. S.), and in the other case the cost was not charged to the HMO (Ms. C.).

Outpatient hospital services

Outpatient hospital services are Medicare part B benefits which are usually paid by intermediaries (Blue Cross) and the requirements for asking HCFA about beneficiary eligibility vary depending on whether a beneficiary has met the annual $75 part B deductible. (See p. 1.) However, except for "emergency" or urgently needed medical services, when Blue Cross makes a payment for such services on behalf of an HMO enrollee, the services should be authorized by the HMO. Blue Cross should notify the HMO of the payment, and if the services were authorized, the HMO should pay the beneficiaries' cost sharing charges. Also, the amounts paid by Blue Cross should be charged against the HMO's capitation payments.

We identified 26 bills for outpatient hospital services paid by Blue Cross (or applied to the part B deductible) for 12 of the 55 IMC, AV-MED, and Broward beneficiaries reviewed in detail. The Blue Cross payments totaled about $5,900, excluding the beneficiaries' cost sharing charges. Six of the payments were consistently processed in all respects in that (1) the services were authorized by the HMOs, (2) the HMOs paid the beneficiaries' cost sharing charges, and (3) the payments were located on the HCFA bill itemization lists to be charged against the HMO capitation payments.

Two paid bills for services not authorized by the HMO were not located on the HCFA bill itemization lists, so those represented payments for noncovered services. For two bills the services were authorized, but the HMO had not paid the beneficiaries' cost sharing amounts as it should have. For the other 16 outpatient hospital bills, the payments were not consistently

handled. Although the payments were shown on HCFA's bill itemization list to be charged to the HMOs, the HMOs' records did not show that the services were authorized, nor did the HMOs have a record of the Blue Cross payments or pay the enrollees' cost sharing amounts, which totaled about $1,500.

For 2 of the 12 beneficiaries, Blue Cross had asked HCFA about beneficiary eligibility and had been advised that they were HMO members. For the other 10 beneficiaries, we did not determine whether Blue Cross was aware they were HMO enrollees at the time the payments were made. In any event there is a coordination problem because if the Blue Cross payments were covered services, the HMOs should have paid the beneficiaries' cost sharing charges. However, if the payments were for non-covered (out-of-plan) services, they should not be charged against the HMOs' capitation payments, but depending on who was at fault, should be recovered from the hospitals or beneficiaries.

HCFA AWARENESS OF THE SYSTEMIC PROBLEMS

HCFA has been aware of the systemic problems discussed in this and the previous chapter involving the HCFA beneficiary eligibility response process for some time. For example, a November 1977 memorandum by the staff responsible for HMOs pointed out that intermediaries had not been sending paid bills for HMO enrollees to the HMOs as they had been instructed to do. This situation led to the development of the HCFA bill itemization lists so that HMOs could have another source of information on their enrollees' utilization.

In December 1984, the same HCFA group was developing a procurement request to obtain telecommunications services to support payments to the HMOs. The justification for the proposed procurement stated that:

> "Early in 1982 the Group Health Plan Operations Staff became concerned about the ability of the current HMO accretion/deletion and record keeping system to meet the need of greatly expanded HMO risk contracting activity. In 1982, the number of risk contracts increased [including the HMO demonstration projects] from one to just over 30. Significant additional growth in the number of contracts and a 50% increase in enrollment is predicted for 1985.
>
> "While the processing system had never been adequate, because it had never operated on the schedule designed; this had not been a significant problem when almost all of the HMO contracts were 'cost' contracts.

Only with [a] large increase in 'risk' contracts did the system require immediate improvement."

. . . . .

"For risk contracts it is extremely important to annotate the [Health Insurance Master Record] quickly when a beneficiary joins and to remove the annotation quickly when the beneficiary disenrolls. The annotation prevents improper duplicate payments. The removal of the annotation permits claims to be paid by Medicare contractors without undue delay in payment after disenrollment."

. . . . .

"The current system has never been capable of making changes in the two files on the first day of the month even for routine transactions. For any transaction containing an error the recording of an enrollment or disenrollment typically takes two or three months.

"Under the current system, when HCFA employees need to determine the status of an individual because of complaints or inquiries from beneficiaries, carriers, intermediaries, congressional staff, etc., it takes a minimum of 10 days just to determine the state of an individual's record in the system."

The proposed procurement is designed to provide more timely access by HCFA and HMO personnel to determine the enrollment status of any beneficiary, but it probably will not result in a more timely recording to the Health Insurance Master File.

CONCLUSION

The time lags between the effective dates of enrollment and the recording of such data on the HCFA files used to respond to hospital admission notices make the system for coordinating the HMOs' operations with the administrative structure for paying hospitals under the regular Medicare program vulnerable to error. As shown in the case studies in appendix II and also in chapter 2, not only are payment errors disruptive to the program and providers but they can also adversely affect beneficiaries. Because of this and the imminent expansion of the HMO program, HCFA should act to correct the payment problems discussed in this and the prior chapter.

RECOMMENDATION

The Secretary of HHS should direct the Administrator of HCFA to take action to identify and correct the systemic problems leading to the erroneous physician and hospital payments we found. Corrective action should center on overcoming the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and problems with the computerized exchange of data among the carriers, intermediaries, HMOs, and HCFA.

CHAPTER 4

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

In addition to the coordination problems involving the HMOs and the administrative structure for paying providers under the regular Medicare program, we identified two other problems associated with the lock-in provisions and the enrollment and disenrollment procedures. The first problem relates to whether and when the HMOs or the regular Medicare program are responsible for the cost of services provided to beneficiaries who are hospitalized during the period from when the beneficiary signs an enrollment form and the effective date of the enrollment and are in the hospital on the effective dates of their enrollment. The second problem relates to beneficiaries who obtain out-of-plan services during the period when they have signed a disenrollment form but must continue to obtain services through the HMO until the effective date of disenrollment.

Solving these problems would involve either a clarification or modification of the law, regulations, and/or related HCFA instructions as contrasted to the basic systemic and internal control problems discussed in the previous chapters.

UNCERTAIN STATUS OF BENEFICIARIES IN THE HOSPITAL ON THE EFFECTIVE DATE OF ENROLLMENT

The enrollment regulations and procedures do not clearly spell out the status of a beneficiary who is hospitalized after he/she signs an enrollment form for an HMO and is in the hospital on the effective date of HMO membership. Under the demonstration projects, this period could range from 2 to 6 weeks. We identified at least seven cases where a beneficiary was in the hospital on the effective date of HMO membership. In at least five of the seven cases, Blue Cross had paid the hospital bill (including the period the beneficiary was enrolled in the HMO) under regular Medicare part A, because the admission and HCFA's response to the inquiry about eligibility status were based on a date before the effective enrollment date. However, in all seven cases most of the related doctor bills for services provided on and after the effective enrollment date were denied by Blue Shield.

Further, because the HMOs did not authorize the hospital admission, their responsibility for these doctor bills was not clear--although our analysis indicated that these seven beneficiaries were without fault. In one case, the HMO routinely paid

for part B services on or after the effective date. In four cases, the HMO had reviewed those claims it received and had paid all or part of them, but in two cases, the HMO had not received any denied claims from Blue Shield and consequently had paid nothing.

Although the incidence of such cases was relatively small, the financial impact on specific individuals and their families was potentially catastrophic. (See cases of Mr. C. S. and Mr. F. in appendix II for examples of individuals hospitalized before their effective enrollment date.)

One solution would be to clearly spell out in the regulations that regular Medicare would be responsible for the portion of the medically necessary hospital and doctor bills up to the effective enrollment date and the HMOs would be responsible for the portion of the bills incurred afterward even though it might not be practical to transfer the medical management of the cases to the HMO. Alternatively, Medicare could be made responsible for all costs until the patient is discharged and the monthly capitation payment proportionately reduced for the days involved.

SERVICES OBTAINED DURING THE DISENROLLMENT WAITING PERIOD

Of the 64 individuals with total denied part B claims over $5,000, at least 14 began to obtain out-of-plan services on the same day or within a week[1] of the date that he/she signed the HMO disenrollment forms. The HMO disenrollment forms included a statement that all services, except "emergency" or "urgently needed" services, had to be provided or arranged by the HMO until the effective date of the disenrollment, which under the demonstrations should have been from 2 to 6 weeks later.[2] Nevertheless, these beneficiaries incurred substantial out-of-plan medical bills for which they were liable during the waiting periods. (See cases of Mr. V., Mr. T. S., and Mr. R. in appendix II.) None of these denied claims were appealed to HCFA under the available formal appeals procedures.

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[1]The normal waiting period was from 2 to 6 weeks. We selected a 1-week period to describe this problem on the assumption that under any modification to the existing HCFA system, it would not be practical to process and record disenrollment more timely than that.

[2]In addition to an indication of the effective date on the disenrollment forms, beneficiaries are later informed by letter from the HMOs of the effective disenrollment dates.

Section 114 of TEFRA and the related January 1985 regulations provide that a member may terminate his/her enrollment with an HMO no earlier than the first day of the second month following the month in which the HMO receives the request for the termination. In other words, under TEFRA if an HMO received the request for disenrollment any time during the month of January, the disenrollment would not be effective until March 1, which would make the waiting period a minimum of about 4 weeks and a maximum of about 8 weeks.

Further, TEFRA provides that enrollees have the right for a hearing (called reconsiderations and appeals) before the government in the case of enrollee dissatisfaction with the failure of the HMO to provide services to which the enrollee believes he/she is entitled, if the amount in controversy is $100 or more. The regulations implementing TEFRA are similar to the previous regulations on beneficiary appeals (42 C.F.R. 405.2056 - 405.2063) for Medicare HMO enrollees, and our review of HCFA reconsideration and appeals files identified no formal appeals to the government involving the four HMO demonstration projects in Florida.

We believe that regular Medicare coverage should be made available for those beneficiaries who obtained necessary services during the waiting period between the date that they apply for disenrollment and the effective date. This could be accomplished by the HMO furnishing the beneficiary with a validated and accepted disenrollment form to accompany any claims to the Medicare paying agents. In our opinion, when a beneficiary is dissatisfied with an HMO service and believes he/she needs medical treatment, the beneficiary should not have to wait several weeks or months to obtain it. On the other hand, if it is eventually shown through complaints and grievances that an HMO was remiss in not providing needed services that a beneficiary obtained out-of-plan shortly after disenrollment, the HMO should be required to accept the responsibility for such services. This would discourage HMOs from withholding treatment as a means of encouraging enrollees with costly health problems to disenroll.[3]

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[3]Although we cannot say such a situation actually occurred, the incentives exist under the TEFRA and demonstration project reimbursement methodology.

CONCLUSION

We believe that individual beneficiaries are most vulnerable to significant costs of out-of-plan services during the waiting period before their enrollment and after their disenrollment. However, as discussed in chapter 2, the beneficiaries, their families, or others had actually paid a relatively small portion (14 percent) of the charges for such services. Nevertheless, we believe that when individuals incur expenses involving thousands of dollars which may not be paid by either the HMO or the regular Medicare program, it could be a traumatic experience. We are continuing to assess the magnitude and specific causes of the problems experienced by beneficiaries entering and leaving HMOs. Our final report will address any necessary corrective actions.

SUMMARY OF DISPOSITION OF DENIED PART B CLAIMS FOR BENEFICIARIES WITH DENIALS OVER $5,000

A summary of the disposition of the denied part B claims for the 64 beneficiaries with denials of over $5,000 each for the four HMOs follows.

SUMMARY OF DENIED PART B CLAIMS FOR IMC ENROLLEES

Of the $338,902 in billed charges that were denied by Blue Shield for the 42 IMC enrollees, we identified about $74,150 that were apparent duplicate denials--that is, claims for the same services submitted more than once and denied each time--including about $2,420 in claims that were allowed and later denied or denied and then allowed.[1] This resulted in net denied claims of about $264,750, of which claims for about $144,015 could be located at IMC.

As of October 31, 1984, the disposition of these denied part B claims was as follows:

	Billed charges
Paid by IMC	$113,790
Under review by IMC	24,130
Paid by beneficiary or family	37,580
Paid by other health insurance	2,150
Retroactively disenrolled by HCFA so that regular Medicare should pay	11,980
Part A services, billed under part B, status of bills is unknown	10,270
Other	6,930
Total	$206,830

[1]We found an additional $11,123 in submitted charges for services provided while the 42 beneficiaries were enrolled in IMC and where Blue Shield incorrectly paid a portion of the charges; however, those claims had been paid when originally submitted and, thus, were not included in the denials.

We contacted the applicable providers about the remaining $57,920 in denied part B claims and were told that about $53,680 had not been paid. We did not determine the status of the remaining $4,240. In some cases we could not identify the providers from the Blue Shield printout so we could not contact them, or we did not contact providers with claims of $60 or less. Case studies of 7 of the 42 IMC enrollees are included in appendix II.

SUMMARY OF DENIED PART B CLAIMS FOR AV-MED ENROLLEES

Of the $84,755 in billed charges that were denied by Blue Shield for the 11 AV-MED enrollees, we identified at least $33,896 that were apparent multiple denials of claims for the same services, including $30,225 in claims that were submitted and denied two or more times and $3,671 in claims that were denied and then allowed. This resulted in net denied claims of $50,859, of which we found records on $46,802 at AV-MED. Also, Blue Shield incorrectly paid claims with submitted charges of $7,622 for the 11 AV-MED members while they were enrolled in the HMO.[2]

The disposition of the $50,859 of denied part B claims is summarized as follows:

Paid by AV-MED	$34,441
Paid by beneficiary or family	1,250
Paid by other (unidentified payee)	1,133
Under review by AV-MED	788
Part B services billed and paid under part A	2,483
	$40,095

For the remaining $10,764 of denied part B claims, we contacted the providers and were told that about $9,477 had not been paid. We did not determine what happened to the remaining $1,287 for various reasons. For example, in some cases the provider could not be identified or contacted, and providers with small claims were not contacted.

Case studies of 3 of the 11 AV-MED enrollees are included in appendix II.

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[2]Of the $7,622 in submitted charges, Blue Shield allowed $5,164.

SUMMARY OF DENIED PART B CLAIMS FOR CAC ENROLLEES

Of the $82,962 billed charges that were denied by Blue Shield for the nine CAC enrollees, we identified $33,691 that were apparent multiple denials (the claims were submitted and denied two or more times), which resulted in net denied claims of $49,271, of which only about $17,162 could be located at CAC. However, upon resubmission, Blue Shield incorrectly paid claims with billed charges of about $7,583,[3] leaving $41,688 to be accounted for. We found that CAC had paid doctor bills with submitted charges totaling about $11,963, leaving about $29,725 in unpaid part B claims.

We contacted 20 providers with outstanding balances of $18,428 and were told that one beneficiary had paid $280. Bills for $310 had been sent to collection agencies. The remaining balance of $17,828 either had been written off as bad debts or was carried as accounts receivable. Five of the providers mentioned that they were not aware that the beneficiaries were members of an HMO at the time they provided the services. When it became apparent to us that CAC enrollees having substantial denied part B claims were not paying the bills themselves, we stopped contacting the providers. Case studies of two of the nine CAC enrollees are included in appendix II.

SUMMARY OF DENIED PART B CLAIMS FOR HEALTH CARE OF BROWARD ENROLLEES

The $15,935 in billed charges that were denied by Blue Shield were applicable to two enrollees. The HMO settled all but $1,720 of the claims which had not been received from Blue Shield or the providers. In one case the HMO had authorized the services, and the claims apparently had been submitted to Blue Shield in error. In the other case, the HMO settled the claims because of apparent confusion concerning the beneficiary's enrollment status.

Case studies of the two Broward enrollees are included in appendix II.

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[3]We identified an additional $8,944 in submitted charges for services provided while the nine beneficiaries were enrolled in CAC and where Blue Shield incorrectly allowed a portion of the charges; however, these claims had been paid when initially submitted and, thus, were not included in the denials.

CASE STUDIES OF SELECTED BENEFICIARIES WITH DENIED PART B CLAIMS OF OVER $5,000

It is important for the Congress, beneficiaries, and other parties to understand how the enrollment and disenrollment process and the administration of the lock-in feature of the HMO demonstration projects affected individuals. Therefore, we are including case studies of 14 of the 64 beneficiaries (7 from IMC, 3 from AV-MED, 2 from CAC, and 2 from Broward). We have included two cases where the system generally worked the way it was supposed to and included other situations where the HMOs eventually paid for services they did not initially authorize. However, most of the cases illustrate one or more of the five problem areas discussed in chapters 2, 3, and 4. Where applicable, before each case we identify by chapter number the type of problem we are illustrating.

IMC ENROLLEES

Mr. V. - This case illustrates the problem in coordinating with the Medicare intermediary and the HCFA hospital admissions notification response process (ch. 3) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4).

Mr. V. was 80 years old when he enrolled in IMC on December 3, 1982, with an effective date of January 1, 1983. On January 13, 1983, he signed a disenrollment form indicating as the reason that regular "Medicare [was] better." Mr. V.'s disenrollment was effective February 1, 1983. According to Blue Shield and Blue Cross claims records, he began seeing other doctors and was hospitalized on the same day he signed the disenrollment form (January 13, 1983).

According to his out-of-plan providers, Mr. V. had a urinary retention (blockage) problem and had gone to the IMC center for assistance and obtained drugs to relieve the condition. When the problem persisted, the IMC center advised him to wait and let the medication work. Because he could not tolerate the pain, he disenrolled and went to private doctors for assistance. On January 17, 1983, he underwent surgery to relieve the problem.

For services during the month of January 1983, Blue Shield correctly denied $6,041 in part B claims for services provided to Mr. V., of which $3,123 was duplicate denials--that is,

claims for the same services submitted and denied more than once--leaving a balance of $2,918 in provider bills, which were the responsibility of Mr. V. because he still was considered as enrolled in IMC. We learned from the providers that Mr. V. had paid $2,003 of the bills, including $1,000 to his surgeon, who accepted this as payment in full for his $1,600 charge. According to the providers, Mr. V. still owed $223. IMC paid $18 to one provider, and we could not determine the status of the remaining $75.

Although the part B claims were correctly denied, the part A intermediary (Blue Cross) on September 5, 1983, paid about $4,381 for Mr. V's hospitalization for January 13 to 24, 1983, while he was still enrolled in IMC. This occurred because when Blue Cross sent the notice of admission to HCFA, it was advised on or about January 18, 1983, that Mr. V. was not enrolled in an HMO. According to HCFA, this incorrect response could have occurred because his January 1, 1983, effective enrollment date had not been annotated on the Health Insurance Master Record until sometime after the admission notice was processed. Although IMC did not authorize this admission nor was there any evidence that Blue Cross determined it was an "emergency," Mr. V.'s hospital bill was charged to IMC for deduction from its capitation payments when Blue Cross sent information on the paid bill to HCFA in September 1983.

Mr. V. requested re-enrollment with IMC on May 13, 1983, at the same center shown on the December 1982 application and, according to IMC records, was reactivated effective July 1, 1983. Mr. V. signed another disenrollment form on August 4, 1983, which indicated that he was dissatisfied with the plan. This disenrollment was effective September 1, 1983; however, on January 4, 1984, Mr. V. again re-enrolled with IMC but requested that he receive services at another IMC center.

Mr. C. S. - This case illustrates the problems in coordinating the denied claims with the Medicare carrier (ch. 2) and the uncertain status of beneficiaries who are in the hospital on their effective enrollment date (ch. 4).

Mr. C. S. was 75 years old when he was enrolled in IMC effective February 1, 1984. According to his wife, he did not intend to enroll and was only requesting information. However, we obtained an application and "Statement of Understanding" apparently signed by Mr. C. S. dated January 10, 1984. On January 25, 1984 (6 days before the effective date of his enrollment), he was hospitalized with a stroke and was in a coma when he became a member of IMC.

When Blue Cross sent the notice of admission to HCFA, it was correctly advised that Mr. C. S. was not a member of an HMO on the date of this admission. Mr. C. S. was hospitalized from January 25, to April 11, 1984; and Blue Cross paid $16,945 of his hospital bill under regular part A, and Mr. C. S.'s private insurance paid $1,810 even though he was a member of an HMO during most of this period.

Blue Shield denied $15,779 in claims for part B services provided during February, March, and April 1984, of which we concluded that $5,149 was previously denied and resubmitted claims, leaving a balance of $10,630 in denied part B claims.

In October 1984 (6 to 8 months after the services were provided), IMC paid $9,377 of Mr. C. S.'s doctor bills. IMC had not received the remaining $1,253 in denied Blue Shield claims and therefore could not have paid them. We contacted a number of the providers and learned that about $853 had not been paid, $175 should not have been billed to Mr. C. S. at all, and the status of $225 could not be determined. IMC paid an additional $1,600 to providers for claims that were not included on the Blue Shield printout of denied and allowed claims. On April 13, 1984, Mr. C. S.'s wife disenrolled him from IMC. The disenrollment was effective May 1, 1984, although she had requested a retroactive disenrollment to February 1, 1984. According to HCFA personnel, they were planning to retroactively disenroll Mr. C. S. so that his doctor bills could be paid by the regular Medicare program, but when we informed them that IMC had paid most of Mr. C. S.'s doctor bills in October 1984, the retroactive disenrollment was not processed.

Mr. F. - This case also illustrates the problem in coordinating denied claims with the Medicare carrier (ch. 2) and the uncertain status of beneficiaries who are in the hospital on their effective enrollment date (ch. 4).

Mr. F. was 79 years old when he enrolled in IMC on January 12, 1984, with an effective date of February 1, 1984. On January 24, 1984, Mr. F. was hospitalized, and on January 25 he requested disenrollment apparently through his wife because he "did not thoroughly understand [the] plan." Because Mr. F. was admitted to the hospital before he became a member of the HMO, Blue Cross paid $6,610 for his hospitalization for January 24 to March 5, 1984, under the regular Medicare program. However,

under the system[1] the disenrollment wa
March 1, 1984, and Blue Shield denied
services provided during February 1984

These denied claims totaled $5,86
duplicate charge, leaving a balance of
providers and learned that the entire
(who had died in July 1984) or his wif
viders, they did not know that Mr. F.
and since the claims were unassigned,[2]
submitted them to Blue Shield. Theref
claims denied by Blue Shield in March
submitted by Mr. F. and that he had be
had been transferred to the HMO.

However, we could not locate any
and according to IMC personnel, nobody
assume responsibility for the bills in
the month he was a member of the HMO.

Under the circumstances of his en
ment, we believe that equity requires
that Mr. F.'s part B claims are reexam
rier.

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[1]As the enrollment and disenrollment s
under the demonstration projects, a p
ment before the middle of a month can
first of the next month. Similarly,
enrollment by the middle of the month
first of the next month. Requests fo
ment after the middle of the month do n
until the first of the month following

[2]Under part B of Medicare, claims can be
assigned. When claims are assigned,
provider, who agrees to accept Medica
the full charge. If the claims are u
made to the beneficiary, who is respo
between the provider's charge and the
The beneficiary is responsible for th
ance amounts under both methods.

Mr. S. - In this case, except for a problem of some relatively small incorrect payments by Blue Shield (ch. 2), the system appeared to work the way it was supposed to.

Mr. S. was 67 years old when he was enrolled in IMC effective July 1, 1983. On October 7, 1983, he was hospitalized on an emergency basis, and on October 9 he died. Blue Shield incorrectly allowed $218 for part B claims totaling $410 and correctly denied claims totaling $6,307. Of this amount, we concluded $1,200 was either denials of resubmitted claims or amounts that should have been included in the hospital bill, leaving a balance of $5,107 of denied part B claims to be accounted for. Of this amount, Mr. S.'s family paid $150, and IMC settled the remaining $4,957 by paying the providers $3,328.

Also, IMC settled another $750 of Mr. S.'s doctors' bills which had not been submitted to Blue Shield by paying the provider $450.

When Blue Cross sent the notice of Mr. S.'s hospital admission to HCFA, it was correctly advised that he was a member of IMC. In February 1984, Blue Cross paid the hospital $5,666, which excluded the $304 part A inpatient deductible. IMC had a record of the Blue Cross payment, and in accordance with the plan's benefits, the HMO paid the deductible. Also, we located the Blue Cross payment on HCFA's bill itemization lists to be charged against IMC's capitation payments.

Thus, except for the $218 incorrectly allowed by Blue Shield and the $150 paid by the enrollee's family, IMC settled all the identified claims associated with Mr. S.'s illness.

Ms. R. This case illustrates the problems in coordinating denied claims with the Medicare carriers (ch. 2) and in coordinating with the Medicare intermediary and HCFA admission notification process (ch. 3).

Ms. R. was 69 years old when she enrolled in IMC on November 14, 1983, effective January 1, 1984. However, on January 14, 1984, she signed a disenrollment form stating she wanted her own doctor. The disenrollment was effective February 1, 1984. On January 28, she was admitted to a hospital through the emergency room as a result of an accident. Blue Shield denied part B claims totaling $7,279 for services provided for January 28 through January 31, 1984, of which we concluded $2,551 were denials of resubmitted, previously denied claims, leaving a balance of $4,728 in provider bills to be accounted for.

IMC settled the emergency room doctor's $110 claim for $82 on May 9, 1984, and in September 1984 (7 months after the services were provided) paid another $3,727 in claims, leaving $891 in denied claims to be accounted for which could not be located at IMC. We contacted the provider who was owed $800 of the $891 and learned that the claim had not been paid, although it probably would be if Blue Shield transferred the claim to IMC. Therefore, we suggested that the provider submit the claim directly to IMC, which the provider did, and IMC paid it.

According to Blue Cross records, when it sent the notice of admission to HCFA, it was incorrectly advised that Ms. R. was not a member of an HMO. On August 13, 1984, Blue Cross paid the hospital $1,735, excluding the $356 part A deductible which IMC should pay, but had not as of October 22, 1984, because it had not received any notification from Blue Cross regarding its payment. We believe that IMC was not notified because Blue Cross records did not show that Ms. R. was a member of IMC. However, when Blue Cross sent information on the paid bill to HCFA, the payment was charged to the HMO for deduction from its capitation payments in October 1984.

Mr. T. S. - This case illustrates the problem in coordinating with the Medicare intermediary and the HCFA admission notification process (ch. 3) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4). It also shows that substantial costs can be incurred by the regular Medicare program by the "retroactive" disenrollment of HMO members.

Mr. T. S. was 67 years old when he enrolled in IMC on December 12, 1983, with an effective date of February 1, 1984. On February 15, 1984, he requested disenrollment from IMC, which became effective March 1, because of a desire to stay with his own doctor. According to his disenrollment interview, Mr. T. S. never used any IMC services.

For part B services provided during February 1984, Blue Shield incorrectly allowed $100 and correctly denied $6,152. IMC paid claims of $180, leaving a balance of $5,972 to be accounted for. In October 1984, we contacted a number of his providers and were told that Mr. T. S. had paid $475 of the doctors' bills and that they had a letter from HCFA indicating that Mr. T. S. was to be retroactively disenrolled from IMC effective February 1, 1984. Presumably, the $6,152 in denied claims for part B services provided to Mr. T. S. while he was a member of the HMO will be processed and, if paid, will be charged to the regular Medicare program.

He was hospitalized from February 16, 1984 (the day after he requested disenrollment from IMC), until March 10, 1984. According to Blue Cross records, when it sent the notice of admission to HCFA, it was incorrectly advised that Mr. T. S. was not a member of an HMO, although technically he was until March 1, 1984. On April 13, 1984, Blue Cross paid $12,118 for this hospital stay. The hospital admission was not authorized by IMC. We could not locate this payment on HCFA's bill itemization lists to be charged to the HMO for deduction from its capitation payments--presumably because Mr. T. S. was to be retroactively disenrolled to February 1, 1984, so that the costs of his hospital stay could be charged to the regular Medicare program.

Ms. B. - This case illustrates the problem of incorrect part B payments by Blue Shield (ch. 2). In addition, it shows how beneficiaries can be confused concerning their enrollment status.

Ms. B. was 67 years old when she apparently enrolled in IMC on December 22, 1982, with an effective date of February 1, 1983. However, at the time she enrolled in the demonstration project, she was not eligible for HMO membership because she did not enroll in Medicare part B until July 1, 1983. In February 1983 HCFA advised IMC that her enrollment could not be effective until July 1, but IMC did not adjust its records. Blue Shield incorrectly paid claims with submitted charges of $854 for part B services provided during the period May 27 through June 30, 1983. These payments were incorrect because Ms. B. was not enrolled in part B. In addition, for services provided from July 1 through August 9, 1983, Blue Shield incorrectly paid claims with submitted charges of $484. These payments were incorrect because during this period Ms. B. was a member of an HMO. In addition, for services provided during May 27 through August 17, 1983, Blue Shield denied claims with submitted charges totaling $5,069, of which $1,212 was denials of resubmitted claims, leaving a balance of $3,857 to be accounted for.

On June 17, 1983, Ms. B. advised IMC that she did not and could not belong to an HMO under any circumstances. However, she refused to sign a disenrollment form that requested a July 1, 1983, effective disenrollment date. Thus on August 4, 1983, IMC processed a disenrollment form on her behalf which became effective September 1, 1983. Of the $3,857 in unpaid part B claims, we learned that Ms. B. had private insurance which settled $1,323, leaving $2,534 outstanding. We were advised by the providers that at least $2,456 of these bills had not been paid as of October 1984.

IMC had paid none of her claims and in February and April 1984 specifically denied claims of $1,815. The remaining claims denied by Blue Shield could not be located at IMC.

During the period IMC records showed Ms. B. was enrolled, she was hospitalized three times: from May 27 to June 3, 1983; July 1 to July 21, 1983; and August 1 to August 18, 1983. According to Blue Cross records, when it sent the notice of the May 27 admission to HCFA, it was advised that Ms. B. was to be a member of IMC effective July 1, 1983. On July 6, 1983, Blue Cross paid about $1,696 for the May admission, and according to the hospital, Ms. B. paid $592. The bills for the July 1 and August 1, 1983, admissions were denied by Blue Cross because the admissions were not authorized by IMC and the response from HCFA correctly advised that she was a member of the HMO. According to the hospital, however, the bills for the July and August admissions were paid by Ms. B.'s private insurance ($8,537). The hospital was carrying a balance due from Ms. B. of $258 for these hospital stays.

In summary, during the 7-month period that IMC records showed that Ms. B. was enrolled in the HMO, she incurred medical expenses of $16,278. The regular Medicare program paid for $3,034, her private insurance covered $9,860, and Ms. B. paid about $592, leaving a balance of $2,792 due to the part B providers and the hospital. Because this beneficiary contended that she never was a member of IMC, she did not obtain her services through IMC, and the HMO has paid nothing.

AV-MED ENROLLEES

Ms. Z. - In this case, except for the problem of coordinating denied claims with the Medicare carrier (ch. 2), the system generally worked the way it was supposed to. However, this beneficiary was indigent, and the cost of the out-of-plan services totaling about $7,797 have been absorbed by her providers.

Ms. Z. was a 61-year-old disabled Medicare beneficiary who was also eligible for Medicaid when she enrolled in AV-MED on January 12, 1983, with an effective date of February 1, 1983. According to Blue Shield records, she began seeing out-of-plan providers on March 2, 1983. However, the earliest date that her part B claims were denied by Blue Shield was May 24, 1983, or over 2 months later. AV-MED thus did not have timely information that this beneficiary was going out-of-plan in order to remind her of the "lock-in" provision. For services provided from March 2 to July 11, 1983, Blue Shield denied claims of $5,354, of which we concluded $2,959 were duplicate denials,

leaving about $2,395 to be accounted for. Of the claims denied by Blue Shield, we found $1,909 at AV-MED. The HMO also denied them because the services had not been authorized by her primary care physician. According to Blue Shield and AV-MED claims records, she had not seen the primary care physician shown on her enrollment form while she was a member of the HMO.

According to Blue Cross, Ms. Z. was hospitalized from May 8 to 20, 1983, with a bill of about $5,403. When Blue Cross sent the admission notice to HCFA it was correctly advised that Ms. Z. was an HMO enrollee. On August 15, 1983, Blue Cross rejected the hospital bill, and AV-MED had no record of the bill.

On July 11, 1983, Ms. Z. disenrolled from the HMO with an effective date of August 1, 1983, stating as the reason that she had changed doctors.

In summary, during the 6-month period she was enrolled in AV-MED, Ms. Z. had incurred about $7,797 in medical and hospital bills, of which neither the regular Medicare program nor the HMO had paid anything. We contacted her providers and were told that none of the bills had been paid.

Ms. C. - This case illustrates the problem of incorrect part B payments (ch. 2) and the lack of coordination with the Medicare intermediary and the HCFA admission notification process (ch. 3).

Ms. C. was 71 years old when she enrolled in AV-MED on June 25, 1983, with an effective date of August 1, 1983. According to Blue Cross records, she was hospitalized from September 2 through October 1, 1983.

When Blue Cross sent the admission notice to HCFA, the intermediary was incorrectly advised that Ms. C. was not a member of an HMO. After receiving updated information from HCFA, and determining the admission was an emergency, Blue Cross paid the hospital $10,188 in January 1984, although there is no record that AV-MED had authorized the admission nor did the HMO pay her inpatient deductible of $304, which it should have paid if the services were "in plan." We could not locate this Blue Cross payment on HCFA bill itemization lists so that it was not charged against the HMO's capitation payments.

For part B services provided from September 1 to 26, 1983, Blue Shield incorrectly allowed $2,610 on submitted charges of $3,250. According to Blue Shield, those claims were processed correctly in accordance with information received from HCFA,

which gave no indication of her HMO enrollment. According to the carrier, it did not receive the correct enrollment information until January 30, 1984, or 6 months after Ms. C.'s effective enrollment date of August 1, 1983.

For part B services provided for September 4 to 17, 1983, Blue Shield correctly denied $5,453 in submitted charges, of which we concluded $3,586 were duplicate denials and $6 was denied and allowed, leaving $1,861 to be accounted for. Of these, AV-MED subsequently paid $1,170 to settle a doctor bill for $1,725 for inpatient hospital services provided on September 7 and 9, 1983. We believe that this payment is inconsistent with the fact that AV-MED did not authorize and was not charged for the cost of the related hospital admission.

According to the claim, the principal service involved surgery related to renal (kidney) failure. While she was still in the hospital, Ms. C. signed a disenrollment form on September 16, 1983, requesting retroactive disenrollment to August 1, 1983. The reason given was "renal disease - needs dialysis." The actual effective date of disenrollment was October 1, 1983.

Mr. W. - In this case the HMO enrollee's hospitalization was handled correctly in accordance with HCFA's instructions but the related doctor bills were not (ch. 2). Also, in this case a doctor was paid by Blue Cross and AV-MED for the same services.

Mr. W. was 66 years old when he enrolled in AV-MED April 4, 1983, with an effective date of May 1, 1983. On July 25, 1983, he disenrolled from AV-MED with an effective date of September 1, 1983. According to his disenrollment form, he wanted to remain with his present doctor. According to Blue Shield records, it correctly denied $169 in claims for part B outpatient services provided between July 25 and August 16, 1983. AV-MED also denied $110 of those claims but paid $55 to settle a claim for $59. On August 27, 1983, or 5 days before the effective date of his disenrollment from AV-MED, Mr. W. was hospitalized for back surgery. This admission was authorized by AV-MED, and when Blue Cross sent the admission notice to HCFA, the intermediary was correctly advised of his membership in the HMO.

For part B services provided in the hospital on August 27 and 28, 1983, Blue Shield correctly denied $5,291 in submitted charges but subsequently settled $3,665 of those claims plus an additional $707 not previously denied for a total of $4,372 in submitted charges, of which Blue Shield incorrectly allowed $2,554. Of the balance of $1,626 in denied claims ($5,291 less

$3,665), AV-MED subsequently paid $826, but the remaining $800 claim could not be located at AV-MED. AV-MED also settled the $3,665 claim previously paid by Blue Shield for $2,376, which resulted in a duplicate payment to this provider.

Blue Cross paid $1,345 of Mr. W.'s hospital bill for August 27 through 31, 1983, while he was a member of the HMO. We located this bill on HCFA's bill itemization lists to be deducted from AV-MED's capitation payments. Also, AV-MED had a record of the Blue Cross payment and paid Mr. W.'s part A inpatient deductible of $304.

In summary, while Mr. W. was a member of AV-MED the HMO covered all his hospital costs of $1,649. In addition, he incurred $6,167 in doctors' bills, of which Blue Shield paid $4,372, leaving a balance of $1,795. AV-MED settled claims for $4,550, of which $3,665 duplicated the claims paid by Blue Shield, leaving $885 in unduplicated denied claims which AV-MED paid. Of the balance of $910 ($1,795 less $885) in claims denied by Blue Shield, AV-MED also denied $110, of which $35 was paid by Mr. W. and $75 was written off as uncollectible. The remaining $800 in denied claims involving assistance at surgery could not be located at AV-MED, but AV-MED probably would have paid it because the HMO paid other doctors' claims that it received associated with Mr. W.'s hospitalization.

CAC ENROLLEES

Mr. R. - This case illustrates the problems in incorrect part B payments by Blue Shield (ch. 2) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4). In addition, in responding to the hospital admission notice, HCFA identified Mr. R. in the wrong HMO.

Mr. R., a 70-year-old beneficiary, was a member of IMC from August 1, 1982, through May 1, 1983. His disenrollment form states, as the reason for leaving, the lack of interest on the part of IMC doctors. During this period, Mr. R. incurred out-of-plan services of $80, which were correctly denied by Blue Shield because of his HMO membership. On March 30, 1983, he applied for membership in CAC which became effective May 1, 1983. According to a statement by Mr. R., after enrolling, he visited a CAC clinic complaining of shortness of breath and chest pains and was referred to another doctor at the clinic. According to Mr. R., he was told that he would have to wait over a month to see this doctor. Therefore, he signed a disenrollment form on May 9, 1983, with an effective date of June 1, 1983. According

to Blue Shield claims records, he was seen by a number of out-of-plan doctors on and after May 9, 1983, and was admitted to the hospital on May 11 for heart surgery and was discharged June 10.

During the 1-month period he was a member of CAC, Mr. R. incurred doctors' bills totaling $12,185 and hospital bills of $23,995, which, according to the hospital, had not been paid by Medicare (Blue Cross), the HMO, or Mr. R. as of October 1984. The hospital had requested Blue Cross to pay the portion of the bill incurred through May 31, 1983, but on May 3, 1984, Blue Cross denied the request because the admission was not considered an emergency. In January 1984 Blue Cross paid the hospital $3,548 for the portion of his hospital stay from June 1 to June 10, 1983, but in June 1984 the intermediary recovered this payment from the hospital.

Some of Mr. R.'s doctors' bills were initially denied by Blue Shield, but during August 9 through October 18, 1983, Blue Shield incorrectly paid claims representing $9,830 of the $12,185, leaving a balance of $2,355. According to its records, CAC paid nothing and on October 20 and November 3, 1983, specifically denied three claims totaling $2,905. Of the amounts denied by CAC, $1,510 was incorrectly paid by Blue Shield, and the remaining $1,395 was included in the unpaid balance of about $2,355. According to the providers, these amounts were either still outstanding or had been written off as uncollectible. The reason for the CAC denials was that the services were rendered without referral or authorization by CAC.

In summary, during May 1983, when Mr. R. was a member of an HMO, he incurred medical bills totaling about $36,180, of which the regular Medicare program incorrectly allowed billed charges of $9,830 and about $26,350 was owed to the providers by Mr. R. or was written off as uncollectible. The HMO paid nothing.

In the 15 months following his disenrollment, Mr. R. incurred hospital bills of $15,221 and doctors' bills of $13,071, of which Blue Shield allowed $9,700. The capitation payments to the HMO for Mr. R. for the 15-month period would have been $4,030.

Ms. G. - This case illustrates the problems of incorrect part B payments by Blue Shield and in coordinating denied claims with the Medicare carrier (ch. 2). It also illustrates a situation where an HMO paid for services although it did not authorize them. Also in this case a doctor was paid by Blue Shield and CAC for the same services.

Ms. G. was 66 years old when she enrolled in CAC on October 15, 1982, with an effective date of November 1, 1982. On November 3, 1982, she disenrolled from CAC with an effective date of December 1, 1982. On November 16, 1982, she was hospitalized for surgery. Blue Cross had no record of this admission. She was discharged on November 25, 1982, with a hospital bill of $9,342. Although the admission was not authorized by CAC, the HMO paid the hospital bill. During this period, Ms. G. incurred doctors' bills of $7,550 which were sent to Blue Shield. During January and February 1983, Blue Shield incorrectly paid bills representing $4,305 of the $7,550, leaving $3,245 which Blue Shield denied. CAC settled $1,075 of the denied claims for $994.

In addition, CAC settled $3,400 of Ms. G.'s surgery bills for $1,858, although subsequently Blue Shield allowed $2,520 for these same services, which represented a duplicate payment to the provider. This left $2,170 in unpaid bills owed by Ms. G. We contacted the out-of-plan providers and learned that (1) nothing had been paid and (2) the providers assumed the bills had been transferred to an HMO because Blue Shield's denial notices said they were. However, our review of CAC files indicated that the HMO had not received these claims. If it had, CAC probably would have settled them because it had paid for other services associated with Ms. G.'s hospitalization while she was enrolled.

HEALTH CARE OF BROWARD ENROLLEES

Mr. M. - This case illustrates the problem of coordinating denied claims with the Medicare carrier (ch. 2) and to some extent the problem of coordinating with the Medicare intermediary and the HCFA admission notification process (ch. 3).

Mr. M. had been a member of the HMO from March 1, 1982, to September 1, 1983, when he was listed as deceased. Blue Shield had denied claims of $9,129 for services provided from March 28 to August 6, 1983, of which $8,638 were paid by the HMO because it had authorized the services, leaving $491 in denied claims which could not be located at Health Care of Broward.

Our analysis of the $8,638 in claims paid by the HMO indicated that they had been received directly from the providers rather than transferred from Blue Shield. Of the $8,638, the claims for $3,052 were dated after the claims had been denied by Blue Shield, which indicated that after the denials the providers had billed the HMO. The claims for $5,586 were billed to the HMO and were dated before the date the claims had been

denied by Blue Shield, which indicates to us that these providers may have billed both the HMO and the regular Medicare program for the same services. In addition, we found $10,570 in paid part B type claims for the member at the HMO that had not been submitted to Blue Shield.

According to Blue Cross records, Mr. M. was hospitalized twice while he was a member of Broward. The first admission covered from June 17 to 29, 1983, and HCFA's response to the admission notice correctly identified him as a member of the HMO. On August 8, 1983, Blue Cross paid $4,617 for this admission. The HMO had authorized the admission and had a record of the Blue Cross payment. For the second hospital admission covering July 20 to August 6, 1983, HCFA's response to the admission notice did not identify Mr. M. as an HMO member. Because the hospital claim included an HMO authorization number, Blue Cross paid $6,507 for this admission on August 31, 1983. However, Broward had authorized the admission and also had a record of the Blue Cross payment so that there was no potential adverse effect resulting from the incorrect or incomplete response.

The unresolved potential problem is that neither we nor the HMO could locate those Blue Cross payments made on behalf of Broward on HCFA's bill itemization lists, which could result in the payments for authorized services not being charged against the HMO's capitation payments.

Ms. T. - This case illustrates the problem of coordinating denied claims with the Medicare carrier (ch. 2). It also illustrates a situation in which an HMO has assumed responsibility for unauthorized services because of apparent confusion concerning a beneficiary's enrollment status.

On March 22, 1983, 69-year-old Mr. T. enrolled himself and his 65-year-old dependent spouse Ms. T. in one of the HMO's private group employer plans with an effective date of April 1, 1983.[3] On April 13, 1983, Mr. and Ms. T. also enrolled in the Medicare demonstration project at Health Care of Broward effective May 1, 1983, apparently on the assumption it was supplemental to the private health insurance obtained through the employer.

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[3]Under section 116 of TEFRA effective January 1, 1983, employers must provide that any employee (or the spouse) ages 65 through 69 shall be entitled to coverage under any group health plan and that Medicare payment would be secondary to or supplement the benefits under the private group plan.

In July 1983, Mr. T. retired and advised his employer that he would seek Medicare supplementary insurance other than through Broward. However, the employer did not advise Broward of this situation until January 13, 1984. Mr. and Ms. T. were disenrolled from the employer group plan effective December 1, 1983. Mr. T. was disenrolled from the HMO Medicare plan effective December 1, 1983, but Ms. T. was apparently not disenrolled until September 1, 1984. During July 20 through October 5, 1983, Ms. T. incurred doctors' bills totaling $6,806 which were denied by Blue Shield. We located $5,577 of these claims[4] at Broward, of which $3,203 was initially denied by the HMO because prior authorization for treatment was not given by an HMO physician.

In October 1984, however, Broward was attempting to settle the $5,577 in claims on behalf of Ms. T. because of the confusion involving the member's enrollment and disenrollment in both the Medicare demonstration project and the HMO's private employer plan. The remaining $1,229 in denied claims were not included in the settlement because the HMO had not received them from Blue Shield.

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[4]Our analysis of these claims showed that they had been addressed to Medicare and were dated before they had been denied by Blue Shield, which indicates to us that they could have been transferred to the HMO from Blue Shield.

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