

GAO

Report to the Honorable
Cardiss Collins, House of
Representatives

August 1990

MEDICAID

Oversight of Health Maintenance Organizations in the Chicago Area





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

Human Resources Division

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August 27, 1990

The Honorable Cardiss Collins
House of Representatives

Dear Mrs. Collins:

This report responds to your request concerning the adequacy of Health Care Financing Administration and Illinois oversight of the quality of care provided to Medicaid recipients by Chicago-area health maintenance organizations (HMOs). It contains our analysis of the financial incentive arrangements used by the two largest HMOs—Chicago HMO and Med Care—and the effectiveness of quality assurance efforts.

Comments on a draft of this report were obtained from the Secretary of Health and Human Services and the Governor of Illinois. Their comments have been incorporated in the final report as appropriate. Copies of the report are being provided to interested committees, the Secretary of Health and Human Services, the Governor of Illinois, the Director of the Office of Management and Budget, and other interested parties.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 275-5451 if you have any questions. Other major contributors are listed in appendix IV.

Sincerely yours,

A handwritten signature in cursive script that reads 'Lawrence H. Thompson'.

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Medicaid pays health maintenance organizations (HMOs) a fixed monthly amount per enrolled recipient (capitation) to provide all health services covered by the program. This gives these HMOs a financial incentive to control the use of services and assure that only necessary care is provided. Although capitation has significant potential for containing health care costs, it also poses the danger of diminished quality of care should an HMO try to cut costs by inappropriately reducing services to Medicaid recipients.

It was alleged, in a series of articles in the *Chicago Sun Times*, that HMOs have been providing poor quality care to Medicaid recipients in the Chicago area. Representative Cardiss Collins asked GAO to evaluate the adequacy of federal and state oversight of the Chicago-area HMOs.

Background

The Illinois Department of Public Aid (IDPA) contracts with HMOs to provide medical services to Medicaid recipients receiving cash assistance under the Aid to Families With Dependent Children program in Chicago and Cook County. As of January 1989, the seven HMOs participating in the program had enrolled approximately 88,000 Medicaid recipients.

Recognizing that HMOs have a financial incentive to limit the amount of care provided, the Congress has required that they have quality assurance programs designed to prevent them from responding to those incentives inappropriately.

Results in Brief

The incentive payment methods used by the largest Chicago-area HMOs—Chicago HMO and Med Care—to control use of health care services could jeopardize the quality of care provided to Medicaid recipients. Individual primary care physicians or small groups of physicians are paid fixed amounts to provide all covered services to enrollees under their care. Under these arrangements, physicians may be forced to pay the cost of some care out of pocket if the cost exceeds the amount they are paid to care for the patients. Thus, under these arrangements, substantial risk is transferred to the physicians, particularly those who have contracted to care for relatively small numbers of patients. These physicians could find themselves in situations (1) for which they will have to make decisions that could cost them money or (2) that would result in inappropriate reductions in service.

Because of the incentives to control the amount and type of services provided, strong HMO management controls are needed to help identify

and prevent physician behavior that could adversely affect quality of care. GAO believes that the controls adopted for Chicago-area HMOs are inadequate. Specifically,

- Neither HCFA nor IDPA has required that HMOs contracting with IDPA include in their subcontracts provisions requiring that the subcontractors provide proof of financial solvency, develop a plan for dealing with insolvency, or enroll a specified percentage of patients who are not on Medicare or Medicaid;
- HMOs' quality assurance programs focus on the use of hospital services, but not on broader quality-of-care issues;
- IDPA has not gathered and analyzed adequate data on the numbers and types of services provided to Medicaid patients; and
- IDPA has been slow to follow up on potential quality-of-care problems.

Principal Findings

Incentives to Underserve

Med Care and Chicago HMO transfer much of the financial risk for the cost of care to medical groups or individual practice associations, which subcontract with the HMOs on a capitation basis. The subcontractors may, in turn, transfer risk to the primary care physicians, paying them fixed monthly amounts to provide care to assigned patients. This gives the physicians a financial incentive to reduce the frequency of services they provide.

The amount of financial risk assumed by the subcontractors or primary care physicians is lowest when they are responsible for providing only primary care services for capitation; the amount increases as the physicians or subcontractors are made responsible for providing a wider range of services for capitation. To earn capitation, Med Care and Chicago HMO subcontractors must provide a wide range of services, including the physician services portion of hospital care, preventive health services, and a variety of outpatient services. Med Care's subcontractors, in turn, transfer risk to their primary care physicians through capitation. HMO officials told GAO that the Chicago HMO does not specify the method its subcontracting medical groups should use to pay physicians and that some most likely use capitation.

Chicago HMO and Med Care use risk pools (see p. 17) to pay for hospital care. Chicago HMO has established a separate risk pool for each of 78

subcontractors serving Medicaid recipients. From 1 to 18 primary care physicians participate in each pool, resulting in a small number of physicians over which to spread risks for costly hospital stays. This small number increases the likelihood that clinical decisions the physicians make will be influenced inappropriately by the cost of implementing those decisions. (See ch. 2.)

Subcontractors Not Required to Meet Medicaid Risk-Based Contracting Requirements

Although Medicaid regulations establish a series of quality assurance requirements for risk-based contractors, HCFA and IDPA have not mandated that similar requirements be imposed on subcontractors. Although the medical groups subcontracting with Chicago HMO and Med Care are essentially HMOs themselves, HCFA and IDPA have not required them to meet what GAO considers to be appropriate risk-based contracting requirements.

For example, the subcontractors' enrollment should include less than 75 percent Medicare and Medicaid recipients. Of the 78 subcontractors with Medicaid enrollees in Chicago HMO, 7 had over 90 percent Medicaid enrollees. Similarly, 9 of Med Care's 25 subcontractors had over 90 percent Medicaid enrollees.

No Minimum Enrollment Requirement Under Medicaid

Under the Social Security Act, HMOs contracting to provide services to Medicare beneficiaries must enroll at least 5,000 members. This is to ensure an adequate base over which to spread the risk of patient care. A similar provision does not apply to HMOs contracting to serve Medicaid recipients. Over half of Chicago HMO's and Med Care's risk-based subcontractors—essentially mini-HMOs—had fewer than 1,000 total enrollees from those HMOs; six spread the risks over fewer than 100 enrollees.

Quality Assurance Programs Inadequate

The quality assurance programs of the Chicago-area HMOs, both HCFA and a private contractor hired as a reviewer concluded, (1) focus primarily on assessing use of hospital services and (2) assess other quality-of-care problems only if they are identified through utilization reviews. IDPA has not effectively followed up to ensure that the Chicago-area HMOs develop effective quality assurance programs. (See ch. 3.)

Utilization Data Inadequate

Illinois did not begin, until fiscal year 1987, (1) requiring HMOs to submit detailed utilization data on Medicaid enrollees and (2) assessing penalties for noncompliance. These actions have not been effective in

ensuring the submission of complete and accurate data. As of January 1990, IDPA had accepted only 40 percent of the utilization data tapes submitted by HMOs. Complete and accurate utilization data are needed for the HMOs and IDPA to detect possible underservicing of Medicaid enrollees and underlying quality-of-care problems. (See ch. 3.)

Inadequate Follow-Up on Potential Quality-of-Care Problems

The Illinois Medicaid agency has not taken effective follow-up action when potential quality-of-care problems are identified. For example, it did not conduct

- a patient satisfaction survey to determine why over 58,000 Medicaid recipients voluntarily left their HMO over a 3-year period and returned to the fee-for-service program or
- reviews of medical records to determine whether preventive health services, which HMOs are required to provide under their contracts with IDPA, are (1) being provided but not documented in the medical records or (2) not being provided. (See ch. 4.)

Recommendations to the Agency

GAO is making a number of recommendations to the Secretary of Health and Human Services concerning strengthening oversight of Chicago-area HMOs. (See pp. 24, 43, and 56.)

Agency Comments

HHS and Illinois generally disagreed with the GAO report, particularly with respect to (1) the appropriateness of the financial incentive arrangements used by Med Care and Chicago HMO and (2) the need to apply appropriate risk-based contracting requirements to sub-contracting prepaid health plans. Neither HHS nor Illinois cited specific actions they planned to correct the problems GAO had identified. (See pp. 25, 44, and 56.)

Recommendation to the Congress

GAO is recommending that the Congress amend the Social Security Act to establish (1) a minimum enrollment requirement for HMOs participating in the Medicaid program and (2) risk-based contracting requirements for Medicare and Medicaid that are more consistent (see p. 32.).

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Abbreviations

AFDC	Aid to Families With Dependent Children
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IDPA	Illinois Department of Public Aid
IDPH	Illinois Department of Public Health
IPA	individual practice association
MMIS	Medicaid management information system
OBRA	Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income
SURS	surveillance and utilization review subsystem

Introduction

Representative Cardiss Collins requested that we review the adequacy of the oversight, by the Health Care Financing Administration (HCFA) and the Illinois Department of Public Aid (IDPA), of Chicago-area health maintenance organizations (HMOs) participating in the Medicaid program.¹ As agreed with Representative Collins's office, we focused primarily on state and federal efforts to ensure that (1) HMO enrollees obtain needed medical care and (2) the care is of an acceptable quality.

Medicaid

Medicaid is a federally aided, state-administered medical assistance program that served about 23.3 million low-income people in fiscal year 1987. The program became effective on January 1, 1966, under authority of title XIX of the Social Security Act, as amended (sections 1396-1396s, title 42, United States Code). Depending on the per capita income in a state, the federal government paid from 50 to 79.8 percent of the Medicaid costs for health services in fiscal year 1989. In fiscal year 1990, nationwide Medicaid payments are projected to be about \$66.8 billion; the federal share is expected to be about \$37.4 billion.

Within broad federal limits, states set the scope and reimbursement rates for the medical services offered and make payments directly to the service providers. Generally, people receiving cash assistance under the Aid to Families With Dependent Children (AFDC) and Supplemental Security Income (SSI) programs are eligible for Medicaid. In addition, at the option of each state, people who do not qualify for cash assistance under these programs, but cannot afford the costs of necessary health care, may also be entitled to Medicaid benefits.

The Department of Health and Human Services (HHS) administers Medicaid at the federal level. Within HHS, HCFA is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations. Each state must designate a single agency to operate its Medicaid program. In Illinois, IDPA is responsible for, among other things, determining eligibility, certifying providers, processing claims, maintaining program integrity, and ensuring that Medicaid beneficiaries have access to medical care of an acceptable quality. For HMO certification and quality of care, IDPA coordinates with the Illinois Departments of Public Health (IDPH) and Insurance.

¹Throughout this report, we use the term "Chicago-area HMOs" to refer to those HMOs in the Chicago area that IDPA has contracted with to provide services to Medicaid recipients. The term does not refer to HMOs that are nonparticipants in the Medicaid program.

Development of HMOs and Other Prepaid Health Plans

States typically pay for services provided to Medicaid recipients on a fee-for-service basis; that is, they pay a provider a fixed amount for every service provided. Because fee-for-service payments create incentives to provide unnecessary services, states have shown increasing interest in prepaid health plans as a way to control unnecessary utilization and thereby contain Medicaid costs. HMOs provide health care to Medicaid recipients in exchange for a fixed, prepaid, monthly payment—called the capitation rate—for each enrollee.

Four common organizational structures for HMOs are as follows:

- Staff HMOs provide services at one or more locations through primary care physicians who are salaried HMO employees.
- Group practice HMOs contract with one independent single-specialty or multiple-specialty group practice to provide services. The physicians in the group share facilities, equipment, medical records, and support staff, but are not employed by the HMO.
- Individual Practice Association (IPA) HMOs contract with physicians in the community to provide medical services, through their regular practices, to HMO members. An IPA HMO may contract with physicians who are members of an association (a network IPA) or may contract directly with individual physicians (a direct contract IPA).
- Network HMOs contract on a capitation basis with more than one medical group or IPA, each offering a full range of comprehensive benefits. Some HMOs are mixed networks because they include a mix of staff, group, and IPA practices.

The Health Maintenance Organization Amendments of 1976 restricted HMO contracts to federally qualified HMOs and required, with limited exceptions, that no more than 50 percent of an HMO's enrollees could be Medicaid recipients or Medicare beneficiaries.² Nationwide, about 282,000 Medicaid recipients were enrolled in HMOs in June 1981.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 gave states greater flexibility in contracting with HMOs or other prepaid health plans. Under OBRA (1981), states are allowed to (1) contract with prepaid health plans other than federally qualified HMOs if those plans demonstrate the capacity to provide covered services and to protect beneficiaries from liability in the event of the plan's insolvency and

²Federally qualified HMOs are those certified by HCFA as meeting the financial, organizational, and quality standards established under the Health Maintenance Organization Act of 1973 (42 U.S.C. 300e).

(2) increase, from 50 to 75 percent, the maximum allowable percentage of Medicare and Medicaid beneficiaries that may enroll in each prepaid health plan.

The federal government gave states the option to use HMOs and other prepaid health plans as a way to contain Medicaid costs; by December 1987, Medicaid enrollment in HMOs and other prepaid health plans had grown to over 1.1 million. Although 28 states and the District of Columbia had one or more prepaid health plans operating at that time, the IDPA program for AFDC recipients in the Chicago area was among the largest.

Since 1974, IDPA had contracted with HMOs to provide comprehensive prepaid health care to AFDC recipients in the Chicago area. In July 1982, only about 4,600 recipients were enrolled in the two federally qualified HMOs participating in the program. Responding to the flexibility provided by OBRA, Illinois began, in 1984, to contract with nonfederally qualified HMOs to enroll Medicaid beneficiaries. In December 1987, about 115,000 Medicaid recipients were enrolled in Chicago-area HMOs. By January 1989, enrollment had declined to about 88,000. For the year ending June 30, 1989, Medicaid paid Chicago-area HMOs about \$62 million (see table 1.1).

Table 1.1: Enrollment of Medicaid Recipients in Chicago-Area HMOs

Dollars in thousands		
HMO	Medicaid enrollees (as of Jan. 1989)	Medicaid payments ^a
American	1,561	\$1,041
Anchor	1,321	1,025
Chicago	60,271	42,533
Compass	1,621	1,210
Illinois Masonic	1,666	1,164
Med Care	21,605	15,107
University of Illinois ^b	0	0
Total	88,045	\$62,080

^aFor year ending June 30, 1989.

^bThe University of Illinois HMO dropped out of the Medicaid program in April 1989 and had no enrollees during fiscal year 1989.

Quality Assurance Requirements

Because capitation gives HMOs and other prepaid health plans incentives to reduce the cost of care, capitation also creates the need for safeguards. They are needed to help protect against potentially excessive

cost-cutting that could affect Medicaid beneficiaries' access to, and quality of, care. Recognizing this potential, the Congress has established a series of quality assurance requirements governing contracts with HMOs and other prepaid health plans. Under federal regulations (42 C.F.R. 434.34), any HMO contracting to serve Medicaid recipients must have an internal quality assurance program that includes

- peer review of the services provided,
- systematic collection of data on the services provided and patient outcomes,
- use of these data to evaluate the care given by each provider, and
- methods for achieving corrective actions when quality-of-care problems are identified.

To help ensure that HMOs have effective quality assurance programs, HCFA requires states to

- conduct periodic medical audits of the HMOs to evaluate their quality assurance programs and determine whether the HMOs are providing quality and accessible health care to Medicaid beneficiaries;
- implement a statewide utilization system to assess the quality of Medicaid services, including those provided by HMOs; and
- contract with a peer review organization for an annual independent external review of the quality of services provided by each HMO.

The peer review requirement was added by the Congress in OBRA (1986); concern was expressed about the quality of services provided by HMOs and other prepaid health plans. We expressed similar concerns in reports on HMOs serving Medicare beneficiaries in Florida and prepaid health plans serving Medicaid beneficiaries in Arizona and Philadelphia.³

Concerns Raised About Abuses by Chicago-Area HMOs

In a series of articles in October 1987, the *Chicago Sun-Times* alleged the two largest HMOs serving Medicaid beneficiaries in the Chicago area were

- using high-pressure sales tactics and forging applicant signatures,
- providing poor quality care as evidenced by an exceedingly high number of malpractice actions,

³See *Medicaid: Lessons Learned From Arizona's Prepaid Program* (GAO/HRD-87-14, Mar. 6, 1987); *Medicaid: Early Problems in Implementing the Philadelphia Health PASS Program* (GAO/HRD-88-37, Dec. 22, 1987); and *Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations* (GAO/HRD-86-97, July 16, 1986).

- seriously delaying care for children, and
- failing to provide high-risk infants with proper follow-up care.

Objectives, Scope, and Methodology

The allegations in the Sun-Times articles led Representative Collins to ask us for an evaluation. In discussions with her office, we agreed to determine whether

- physician incentive plans and compensation arrangements used by the largest Chicago-area HMOs could lower the quality of care provided,
- quality assurance programs are adequate to identify and correct quality-of-care problems, and
- IDPA effectively follows up on potential quality-of-care problems.

Our work was done at HCFA headquarters in Baltimore; HCFA's regional office in Chicago; IDPA and IDPH in Springfield and Chicago, Illinois; and Chicago HMO and Med Care. We also visited the Illinois Department of Insurance to identify licensing and solvency requirements for HMOs.

To assess the adequacy of HCFA, IDPA, and the HMO quality assurance efforts, we reviewed

- laws, regulations, and other guidance relating to quality assurance;
- audits and other evaluations of the Chicago-area HMOs by certified public accountants, the state, and a peer review organization (Crescent Counties Foundation for Medical Care);
- HCFA evaluations of IDPA's oversight activities;
- HCFA evaluations of contracts to determine (1) the thoroughness of the evaluations and (2) whether HCFA had raised any questions; and
- IDPA's contracts with the HMOs.

We also interviewed

- HCFA, IDPA, Chicago HMO, and Med Care officials to (1) determine what actions they took to resolve problems identified by the audits and (2) discuss limitations in audit methodologies and
- HCFA and IDPA officials to determine the status of efforts to establish criteria for utilization reporting on HMOs and peer review organization reviews of HMOs.

In addition, we obtained and analyzed statistical reports on enrollments and disenrollments as well as health care utilization.

We also attempted to develop a comparison of health services utilization by HMO enrollees (1) before enrollments, (2) during enrollment, and (3) following disenrollment. We planned to match fee-for-service utilization data from the state's Medicaid Management Information System (MMIS) with data from the medical records of a random sample, done by Crescent Counties Foundation for Medical Care, of HMO enrollees. Because of the poor documentation of services in the medical records of the HMO enrollees, however, the Crescent Counties samples did not provide sufficient detail to permit the type of analysis planned.

Our work was done between November 1987 and August 1989 in accordance with generally accepted government auditing standards.

Incentive Payment Methods Used by Largest Chicago-Area HMOs Could Jeopardize Patient Care

The incentive payment methods used by the largest Chicago-area HMOs—Chicago HMO and Med Care—could jeopardize care provided to Medicaid recipients. Both HMOs use capitation to shift significant risk for primary care services to individual physicians or small groups of physicians subcontracting with the HMOs. The HMOs also shift much of the risk for hospital and specialist services to the subcontractors, some of which have few enrollees over which to spread the risk and few providers to absorb any losses that might be incurred. These are among the HMO financial arrangements we cited in a December 1988 report as potentially leading to adverse effects on quality of care.¹

Strong HMO management controls are needed to help identify and prevent physician behavior that adversely affects quality of care, especially for arrangements such as those used by Chicago HMO and Med Care; these arrangements can place individual physicians at high risk and closely relate clinical decisions to financial gain. Although Medicaid regulations establish a series of quality assurance requirements for risk-based contractors, IDPA and HCFA have not mandated that similar requirements be imposed on subcontractors. Specifically, neither HCFA nor IDPA requires that Chicago HMO and Med Care include in the subcontracts provisions requiring that subcontractors develop a plan for dealing with insolvency or enroll a specified percentage of private members.

Unlike the Medicare program, which requires an HMO to enroll at least 5,000 members in order to adequately spread the risks of patient care, there is no minimum enrollment requirement under Medicaid. One of the HMOs participating in the Chicago-area HMO program had fewer than 2,000 members, and none of Chicago HMO's or Med Care's subcontractors would have met the Medicare minimum enrollment requirement, based on enrollment information from each HMO.

High turnover of Medicaid recipients enrolled in the Chicago-area HMOs could increase the incentives to inappropriately delay or deny care. This is because the adverse effects of such actions might not occur until after the recipient has left the HMO.

¹ Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Certain HMO Financial Arrangements Could Lead to Adverse Effects on Quality of Care

Although all HMOs contracting on a risk basis have a financial incentive to control the amount of care provided, some HMO physician incentives could induce physicians to respond in a way that could lead to improper patient care. Generally, the closer financial incentives are to individual treatment decisions and the more risk the physician has, the higher the potential for adverse effects on quality of care.

The financial incentives to control utilization vary by type of HMO. For example, staff model HMOs provide services through salaried primary care physicians; such physicians do not directly benefit financially by limiting the services they provide. Other types of HMOs, however, generally provide financial incentives to physicians to control (1) use of primary care services, (2) referrals to specialists, and (3) hospital admissions. The funds for these incentives normally come from two sources:

- the difference between the capitation payment for the enrollee and the actual costs of caring for the enrollee and
- risk pools, composed of funds withheld from payments to physicians.

Capitation

To give primary care physicians an incentive to control utilization of medical services, HMOs may establish capitation payment mechanisms; these mechanisms require primary care physicians or groups of physicians to accept a monthly designated amount as payment in full for each assigned enrollee, no matter how often the physician or group of physicians provides services to the enrollee during the month or how much the services cost. This shifts substantial portions of financial risk for medical services from the HMO to the primary care physicians; an individual primary care physician or group of physicians can gain or lose financially depending on the frequency or extent of patient services.

In our December 1988 report, we stated that the amount of financial risk transferred from the HMO to the physician or group of physicians is lowest when the capitation covers only primary care services; the risk increases as the physician or group of physicians is made responsible for a wider range of services, such as care by specialists and hospital care.

Risk Pools

HMOs usually form risk pools by withholding a portion of each primary care physician's or subcontractor's compensation. The withheld funds represent the physician's or subcontractor's risk sharing in the HMO's overall cost of health services to be paid for from funds in the risk pool.

If an enrollee needs specialty or inpatient services, the primary care physician is generally responsible for approving (1) the referral to a specialist or (2) the admission to a hospital or other institution. Payments for those services are deducted from the funds established for specialty or institutional services.

Depending on the use of health services, risk pools can show either a surplus or a deficit at the close of the accounting period. Surpluses are paid to the primary care physicians or subcontractors as incentives. In the case of deficits, some HMOs limit the risk of primary care physicians to the amount of funds withheld and deposited in the risk pool and absorb the deficit out of HMO funds. Others hold physicians responsible for deficits exceeding risk pool amounts, requiring them to make up deficits through decreased future payment rates, higher percentages withheld for the risk pool in the future, or direct repayment to the HMO. Under such an arrangement, the larger the number of primary care physicians sharing surpluses or deficits, the less any one physician's behavior is likely to influence the size of the pool's surplus or deficit.

Our December 1988 report identified certain HMO financial arrangements that could jeopardize the care provided to enrollees. For example, we concluded that

- the more risk shifted to physicians, the greater the potential effect on physicians' income and the greater the potential for inappropriate reductions in services and
- the fewer physicians and patients over whom cost performance is measured, the more individual treatment decisions affect incentive payment amounts and the greater the temptation to delay or withhold referral for needed care.

Chicago HMO and Med Care Financial Arrangements Among Riskier Approaches

The financial arrangements used by Chicago HMO and Med Care, as well as their subcontracting medical groups, include several features discussed above that are likely to adversely affect quality of care. Specifically, both are network-type HMOs, (1) shifting substantial risk to subcontractors that function essentially as mini-HMOs and (2) distributing incentives based on the performance of these subcontractors, frequently composed of a handful of primary care physicians. The subcontractors, in turn, may, through capitation, shift substantial risk to individual physicians.

Chicago HMO and Med Care most closely resemble a network HMO in the following ways:

- Chicago HMO subcontracts on a risk basis (see p. 20) with 78 medical groups, owned and operated by private entities, to provide services to Medicaid recipients. These groups agree to provide comprehensive services to Chicago HMO members.
- Med Care contracts on a risk basis with 25 IPAs to provide comprehensive services to Medicaid recipients.

The incentives to control utilization may be greater under network HMOs such as Med Care and Chicago HMO. This is because the HMO passes many of the risks of its enrollees' health care costs to subcontractors that may have relatively small numbers of providers and enrollees over which to spread the risks. Both Med Care and Chicago HMO subcontract on a risk basis for a wide range of services, including care provided by physicians in a hospital; preventive health services; drug and alcohol abuse detoxification; and such outpatient services as physical therapy, radiation therapy and chemotherapy, and surgical procedures.

According to the president of IPA Management Corporation,² the IPAs subcontracting with Med Care pay their primary care physicians on a capitation basis. A typical primary care physician receives about 50 percent of the overall capitation Med Care pays to the IPA. Each IPA has a different mechanism for putting the primary care physician at risk for the costs of certain laboratory tests, a portion of emergency room care, and incentive withholds. Several IPAs deduct \$25 from the primary care physician for each emergency room visit by an HMO enrollee.

Chicago HMO does not obtain data on the methods its subcontracting medical groups use to pay their physicians. The vice president of Chicago HMO said that overall, every payment combination, including capitation, is most likely used; the specific combination depends on the structure of the medical group.

Chicago HMO establishes a separate risk pool, known as a medical incentive fund, for each group of providers subcontracting with the HMO. As of January 1989, Chicago HMO's 78 medical groups serving Medicaid beneficiaries ranged in size from 1 to 18 primary care physicians. A portion of the monthly capitation payment received from the state is paid into

²Subsidiary of Health Care Management, Inc., a for-profit corporation that, under contract, provides management services to Med Care.

the risk pool for each Medicaid recipient assigned to the group; payments vary by age and sex of the recipients. The risk pools are used to pay charges for, among other things,

- inpatient hospital care up to \$40,000 per enrollee per year,
- in-area emergency room services,
- out-of-area emergency care,
- home health care,
- nursing home care,
- durable medical equipment, and
- ambulance services.

Each group receives 60 percent of any funds remaining in the risk pool at the end of the year. If there is a deficit in the risk pool, it is charged against the pool for the following year, thereby limiting the HMO's risk and increasing the incentive for physicians in the group to control utilization. As stated in our December 1988 report, the more physicians and patients over whom cost performance is measured, (1) the farther individual treatment decisions are removed from incentive payment amounts and (2) the less likely reduction of quality will occur. The small number of physicians covered by each of Chicago HMO's risk pools increases the incentive for primary care physicians to inappropriately delay or deny services paid by the risk pool.

To pay for inpatient services, Med Care also establishes a risk pool for each of the 25 IPAs, allocating funds by age and sex of the recipient. Each IPA receives 50 percent of any surplus remaining in the pool at the end of the year.³ If expenses exceed the funds available in the pool, however, the deficit is absorbed by Med Care.

Subcontractors Not Required to Comply With Risk-Based Standards

Transferring substantial risk to individual physicians or small groups of physicians heightens the need for effective quality assurance monitoring. HCFA and IDPA have imposed Medicaid risk-based contracting requirements on the primary contractors—the HMOs—but have not required that HMOs incorporate risk-based requirements in their subcontracts with the medical groups. These risk-based requirements include provisions (1) relating to financial solvency and (2) limiting the percentage of their enrollments that could be composed of Medicare beneficiaries and Medicaid recipients.

³Each IPA also receives 50 percent of any additional surplus resulting from Med Care's revision of an expense estimate from the budget for that calendar year.

Under Medicaid regulations, HMOs that contract with a state Medicaid agency on a risk basis must comply with certain risk-based requirements. For example, HMOs are required to have

- a fiscally sound operation and a plan for handling insolvency,
- less than 75 percent Medicare beneficiaries and Medicaid recipients in their enrollment, and
- a quality assurance program.

All subcontracts are required to be in writing and fulfill the contracting requirements appropriate to the service or activity delegated under the subcontract.

HHS does not require that prime contractors include in their subcontracts provisions relating to financial solvency or percentage of private enrollments. Both Med Care and Chicago HMO allow subcontractors to have more than 75 percent of their enrollees Medicaid recipients. As of July 1, 1989, 76 percent of Med Care's overall enrollees were Medicaid recipients; 17 of the subcontracting IPAs had more than 75 percent Medicaid recipients; 9 of the 17 had more than 90 percent Medicaid recipients. Overall, Chicago HMO subcontracted with 78 medical groups that had Medicaid recipients (as of June 1989). Of these, 19 (24 percent) had 75 percent or more Medicaid recipients. Seven of the 19 had over 90 percent Medicaid recipients.

Med Care's and Chicago HMO's subcontracts with medical groups do not require that the groups have a plan for handling insolvency. Neither the financial audits conducted by public accounting firms nor the compliance audits conducted by IDPA have addressed the enrollment mix or financial solvency provisions as they apply to the subcontractors.

Minimum Enrollment Requirement Does Not Apply to Medicaid HMOs and Their Risk-Based Subcontractors

Although the Social Security Act sets a minimum enrollment requirement for HMOs participating in the Medicare program, in order to help ensure an adequate base over which to spread the risks, no comparable requirement exists for HMOs participating in the Medicaid program either for the HMO or its subcontracting medical groups. Both Chicago HMO and Med Care have enough enrollees overall to meet the Medicare standards; none of the medical groups subcontracting on a risk basis, however, would meet such standards. And, one HMO—Illinois Masonic—participating in the Chicago-area program would not have met the standards for participating in the Medicare program.

Chapter 2
Incentive Payment Methods Used by Largest
Chicago-Area HMOs Could Jeopardize
Patient Care

A network HMO parcels out its enrollees to affiliated provider groups and transfers much of the risks of patient care to them; therefore, the potential exists for an affiliated provider group to have an enrollment base so low that it may not be able to consistently function profitably and also provide quality care. While we do not know at what level of enrollment this would happen, some level certainly exists.

Under the Medicare program, HMOs are required to enroll at least 5,000 members (section 1876 of the Social Security Act) in order to adequately spread the risks of patient care.⁴ Although a comparable requirement does not exist for HMOs participating in Medicaid, we believe the Medicare contracting requirement provides a reasonable criterion for evaluating HMOs participating in Medicaid.

None of Chicago HMO's or Med Care's affiliated provider groups would have met the Medicare enrollment requirement.⁵ As shown in table 2.1, over half of Chicago HMO's provider groups had fewer than 1,000 total enrollees; 3 provider groups had fewer than 100 total enrollees. Similarly, of Med Care's 25 IPAs serving Medicaid recipients, 14 had fewer than 500 total enrollees; 3 had fewer than 100. One Med Care IPA had only 3 enrollees, all Medicaid recipients.

Table 2.1: Enrollment of Chicago HMO and Med Care Affiliated Provider Groups Serving Medicaid Recipients (1989)

Range of enrollment	Provider groups	
	Chicago HMO ^a	Med Care ^b
5,000 or more	0	0
Subtotal	0	0
4,000 - 4,999	1	1
3,000 - 3,999	4	2
2,000 - 2,999	10	3
1,000 - 1,999	20	3
500 - 999	26	1
100 - 499	14	12
1 - 99	3	3
Subtotal	78	25
Total	78	25

^aAs of June 1989.

^bAs of July 1, 1989.

⁴Rural HMOs must have 1,500 enrollees.

⁵Some provider groups subcontract on a risk basis with more than one HMO. We considered only the number of enrollees under a specific subcontract with Chicago HMO or Med Care.

**High Enrollee
 Turnover Could
 Heighten Incentives to
 Delay or Deny
 Services**

Rapid turnover of Medicaid recipients enrolled in the Chicago-area HMOs, primarily for reasons beyond the control of the HMOs, could, in our opinion, heighten the incentives to inappropriately delay or deny services to Medicaid recipients. This turnover reduces the moderating effect of factors such as (1) the need to retain enrollees and (2) the knowledge that skimping on or delaying medical care could necessitate more expensive care in the future.

A 1987 study on disenrollments of Medicaid recipients from Chicago-area HMOs found that (1) over 30 percent disenroll within 6 months, 45 percent within 1 year, and over 80 percent within 3 years of enrollment and (2) membership retention has a direct implication for HMO stability, as well as quality and quantity of services provided to members.⁶

Over a 3-year period, 37 percent of the Medicaid recipients studied were involuntarily disenrolled from a Chicago-area HMO because of a change in their Medicaid eligibility.⁷ A Medicaid recipient, the president of Med Care stated, usually remains at Med Care only 5-1/2 to 6 months.⁸ High numbers of disenrollments of Medicaid recipients from Chicago-area HMOs continue to occur, as shown in table 2.2.

Table 2.2: Disenrollments of Medicaid Recipients From Chicago-Area HMOs (1986-88)

Fiscal year	Type of disenrollment		Total
	Involuntary ^a	Voluntary ^b	
1986	17,188	16,790	33,978
1987	27,883	24,893	52,776
1988	30,598	16,469	47,067

^aInvoluntary disenrollment results from a change in Medicaid eligibility. This can occur under these circumstances: the recipient's income exceeds AFDC eligibility levels; the recipient moves out of Cook County; or eligibility case workers suspend Medicaid eligibility. The latter may happen if the recipient does not (1) keep appointments or (2) supply all required information. HMOs have no control over involuntary disenrollments.

^bVoluntary disenrollment occurs when a Medicaid recipient chooses to disenroll from an HMO because he or she (1) is having problems gaining access to care, (2) is dissatisfied with the care being provided, (3) feels that the HMO misled him or her into enrolling, (4) did not understand the concept of an HMO, or (5) prefers a different location or physician

⁶Medhi Nassirpour and Gary Giacomelli, "Disenrolling From Health Maintenance Organizations Among Illinois Medicaid Beneficiaries," *Social Services Review*, vol. 72, no. 2 (Jan. 1988), pp. 91-95.

⁷Nassirpour and Giacomelli, "Disenrolling."

⁸In testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (Feb. 11, 1988).

In our opinion, HMO physicians may have an incentive to delay providing needed services to Medicaid recipients if they know that these enrollees will usually disenroll within 5-1/2 to 6 months. This is particularly true for preventive health services, such as immunizations and cancer screening, where the adverse effects of delaying treatment are unlikely to occur before the recipient disenrolls. HMOs serving private-pay enrollees have an incentive to provide preventive health services to (1) attract and help retain these enrollees and (2) reduce future health care costs. Because retention of Medicaid recipients is largely beyond the control of HMOs, the incentive to provide such services may be lacking.

Conclusions

The organizational structure of Chicago HMO and Med Care shifts much of the risk to subcontractors, which function essentially as mini-HMOs. The payment methods used by both HMOs (1) create strong financial incentives for their subcontractors and primary care physicians to control the use of Medicaid services and (2) could lead to inappropriate reductions in services unless adequate safeguards exist. However, the subcontracting health plans have not been required to (1) prove their financial solvency, (2) have a sufficient number of enrollees to spread the risk, or (3) limit their enrollment of Medicaid recipients to less than 75 percent of total enrollment.

The need of an HMO to retain private-pay enrollees is a strong incentive to satisfy an enrollee; delaying or denying care may result in (1) an enrollee's choosing another health plan or (2) higher costs of caring for an enrollee's medical condition that was not promptly identified and treated. For Medicaid enrollees in Chicago-area HMOs, however, there is a good chance that an enrollee will lose Medicaid eligibility before any adverse effects of underservicing are evident; in addition, there is little risk to the primary care physician from underservicing. Thus, high involuntary disenrollments from Chicago-area HMOs may heighten the incentives to delay or deny needed medical services.

Recommendation to the Secretary of HHS

We recommend that the Secretary, through the HCFA Administrator, direct IDPA to require HMOs to do the following: when HMOs enter into contracts on a risk basis, the HMOs should require their subcontracting health plans to comply with standards for risk-based contracting. Specifically, subcontracting health plans should be required, in writing, to

(1) prove their financial solvency, (2) have a plan for handling insolvency, and (3) hold the number of Medicaid recipients to less than 75 percent of total enrollment.

HHS Comments and Our Evaluation

Overall Comments

HHS (see app. II) said that it was concerned with our “general criticism” of HMO provider capitation methods. Our report, HHS said, conveys an overall impression that HMOs in general “pose the danger of diminished quality of care.” HMOs can, HHS said, improve access to health care for Medicaid enrollees who may have limited access to providers in the fee-for-service setting.

We do not mean to imply that HMOs in general provide poor quality care or that the same risks to patient care exist under all HMOs. As stated on page 2, however, we believe that capitation “poses the danger of diminished quality of care should an HMO try to cut costs by inappropriately reducing services to Medicaid recipients [emphasis added].” Capitation creates the need for safeguards to help protect against potentially excessive cost-cutting that could affect Medicaid beneficiaries’ access to, and quality of, care. It is the inadequacy of such safeguards in the Chicago-area HMO program that creates an unacceptable risk of diminished quality of care for Medicaid recipients.

To the extent that additional providers agree to provide services to Medicaid recipients, we think that HMOs have the potential to improve access for Medicaid recipients. Access is improved, however, only to the extent such providers actually provide needed services. As discussed in chapter 3, HCFA and IDPA have little data to determine whether needed services are being provided.

Presumption That Capitation Will Lead to Inappropriate Reductions in Services

HHS said that it does not agree with the “GAO presumption” that capitation and risk pools will, in all likelihood, lead to inappropriate reductions in medical services for Medicaid recipients. According to HHS, the Chicago-area HMOs use capitation and risk pool methods “identical or similar to” those used by commercial HMOs, providing quality health care services to over 32 million enrollees, including employees of the federal

government. HHS said that our attempt to demonstrate that “accepted industry-wide capitation payment standards” lower quality of care is conjectural and inconclusive. According to HHS, we hypothesized that fewer services would be provided to Medicaid enrollees serviced by capitated providers, but failed to prove that services were not provided as a result of the capitation and risk pool arrangements.

We are not suggesting that capitation and risk pools will automatically result in inappropriate reductions in medical services to Medicaid recipients. We state (p. 17) that the closer financial incentives are to individual treatment decisions and the more risk transferred to the physician, the higher the potential for adverse effects on quality of care. This, in turn, heightens the need for effective quality assurance monitoring.

We recognize that in assessing the appropriateness of physician incentives, it is important to consider mechanisms established to counterbalance the incentives and the effectiveness of those mechanisms in operation. As detailed in this chapter, some of the primary quality assurance requirements applied to HMOs have not been applied to the risk-based subcontractors; as discussed in chapters 3 and 4, the quality assurance mechanisms that are in place are not working effectively.

Chicago HMO and Med Care do not use capitation and risk-pool methods “identical or similar to” those used by most commercial HMOs. As discussed in our December 1988 report, there is wide variation in the types of primary care compensation arrangements used by HMOs. For example, of 19 Medicare HMOs reviewed, 8 did not use capitation with primary care physicians, paying them either on a fee-for-service or salaried basis. And of the 11 that paid primary care physicians on a capitation basis, 6 required the primary care physicians to provide only primary care services out of the capitation; 4 required the primary care physician to provide primary care and specialist services out of the capitation; and 1 required the physician to provide all health services, including hospital care, out of the capitation.

To our knowledge, there are no “accepted industry-wide capitation payment standards,” as HHS maintains. In fact, as we reported in December 1988, there is no consensus among interest groups as to the appropriateness of physician incentive plans. For example, the American Medical Association has taken the position that HMO plans providing financial incentives to restrict needed medical services are unethical and should be prohibited. The Group Health Association of America, an association

representing HMOs, however, said that quality assurance plans and overall performance of an HMO should be assessed before assuming that distributing incentive funds on the basis of individual physician performance is a problem.

Finally, the Blue Cross and Blue Shield Association (in a statement submitted for the record at an April 25, 1989, hearing, held by the Subcommittee on Health, House Committee on Ways and Means) recommended that certain types of physician incentive arrangements be prohibited by law. Specifically, they recommended that the law prohibit

- arrangements in which the physician's compensation is directly tied to treatment decisions made for an individual patient,
- HMOs from entering into Medicare contracts if their compensation arrangement puts physicians at risk for more than 30 percent of the base capitation, and
- capitation for which the capitated patient population is small, unless some limit is set on liability of the individual physician or small group of physicians.

If the Blue Cross and Blue Shield proposal were enacted into law, it would appear to prohibit the kind of financial incentive arrangements currently employed by Chicago HMO and Med Care.

HHS commented that we failed to prove that services were not provided as a result of the capitation and risk pool arrangements. As discussed in chapters 3 and 4, there are many studies questioning whether needed services are being provided. We believe it is HCFA's and IDPA's responsibility to follow up on those studies to ensure that needed medical care services are provided; adequate data are not being collected to enable us, HCFA, or IDPA to conclude either that needed services are being provided or are not being provided.

No Study Has Demonstrated That Capitation Reduces Quality

HHS said that although general concern has been expressed about HMO financial incentive arrangements in the past, no study has ever demonstrated that capitation reduces quality of care. A recent HHS report to the Congress on financial incentive plans in Medicare-contracting HMOs states that

“there is no evidence available to support the hypothesis that these plans result in unacceptable levels of care and poor quality. Similarly, there is no evidence to support the hypothesis that some financial incentives have more influence on behavior than others, and therefore, more potential influence on quality than others.”

We agree that studies evaluating the effects of financial incentive arrangements on quality of care are not available. We reported the absence of such studies in our December 1988 report. We believe, however, that without studies evaluating the effects of financial incentives on physician behavior, HHS or others should not assume that physicians respond to all incentives in the same way. The HHS report also states that “it is probable that some incentive arrangements have a stronger effect on physician behavior than others.” In addition, it is likely that incentives directly influencing clinical decisions probably have the greatest potential for affecting quality of care. Components of these arrangements are, the HHS report states, (1) the size of the group of physicians sharing in the risk and (2) the portion of the physician’s total income or compensation that comes from the plan.

We continue to believe, as we stated in our December 1988 report, the following: Incentive plans that expose the physician to substantial financial risk for services provided by other physicians or institutions or closely link financial rewards with individual treatment decisions or both (1) pose the greatest threat to quality and (2) necessitate the highest level of quality assurance control. In this report, we show that effective quality assurance mechanisms are not in place to counterbalance the strong financial incentives given to Chicago HMO and Med Care primary care physicians. Further, neither we nor others will be able to directly assess the effects of the financial incentives on patient care until HMOs fully and accurately document the medical care services provided (see p. 37).

In our opinion, financial incentive plans that closely tie treatment decisions to financial gain or loss should not be allowed until HHS ensures that (1) the HMO has an effective internal quality assurance plan and (2) the state Medicaid agency has an effective utilization-reporting system to determine whether the financial incentives are having an adverse effect on patient care. As discussed on pages 44 and 45, HHS identified no specific plans to generate the data that would enable us or others to conclude that quality care is being provided.

Capitation Encourages Appropriate Use

Capitation is, HHS said, intended to adequately compensate providers that appropriately manage an enrollee's total health care needs. Financial risk is, HHS notes, an essential element of capitation and serves the purpose of (1) preventing unnecessary or inappropriate utilization and (2) encouraging the provision of care in the appropriate setting.

We state on page 2 that capitation gives HMOs a financial incentive to control the use of services and assure that only necessary care is provided. We also agree that financial risk is an essential element of capitation arrangements. Not all HMOs, however, handle that risk in the same way. Some HMOs, for example, pay physicians on a fee-for-service or salaried basis and use such tools as physician education programs, peer review, and utilization reviews to manage an enrollee's total health care cost. Because most risk is retained at the corporate level, individual treatment decisions are not closely tied to financial gain. Other HMOs, such as Chicago HMO and Med Care, transfer most of the risks to subcontractors. By transferring most risk, they insulate themselves from the need to manage enrollees' health care utilization. That responsibility then falls on the subcontractor or primary care physician.

Disapproval of Provider Risk-Sharing Arrangements

HHS said that our report does not approve of provider risk-sharing arrangements. Federal law, HHS said, permits federally qualified HMOs and Medicare-contracting HMOs to arrange for physicians or institutions to assume all or part of the financial risk for providing health services. Further, the HHS report on provider financial incentives was meant to assist the Congress in its determination of risk arrangements that should not be permitted in Medicare. It would be inappropriate, HHS believes, to prohibit specific risk arrangements under either Medicare or Medicaid unless the Congress passes legislation.

We are not suggesting that HHS prohibit specific risk arrangements. What we are suggesting, however, is that HHS (1) focus its quality assurance efforts on HMOs that transfer most risk to individual physicians or subcontractors, (2) use the Medicaid contracting standards to ensure that the subcontractors have the financial capacity to assume the risks being transferred, and (3) require that medical groups subcontracting on a risk-comprehensive basis be required to meet the patient-mix requirements (see p. 20.). As discussed above, the HHS report recommends that certain physician incentive plans be prohibited based on the potential for adverse effects on quality of care.

Minimum Enrollment Requirement Would Be Inappropriate

HHS said that it would be inappropriate to apply the Medicare minimum enrollment requirement to Medicaid HMOs because there is no correlation between the minimum enrollment of 5,000 members and risk arrangements with individual physicians. We incorrectly assert, HHS said, that the 5,000-member requirement ensures an adequate base over which to spread risk, thereby lessening the likelihood that an individual physician's clinical decisions will be made for financial reasons. HHS notes that the minimum enrollment standard applies to the HMO, not to subcontracting providers.

We state on page 22 that we do not know at what level of enrollment a provider group would have an adequate base over which to spread the risks of enrollees' health care costs, but that such a level certainly exists. One possible base was suggested by the Blue Cross and Blue Shield Association in April 25, 1989, testimony submitted for the record to the Subcommittee on Health, House Committee on Ways and Means. The association recommended that capitation arrangements be prohibited when the patient population is small (for example, fewer than 100 patients) unless some limit is placed on the liability of the individual physician or, small group of physicians. As shown on page 22, 3 of Chicago HMOs' 78 subcontractors and 3 of Med Care's 25 subcontractors had enrollments of fewer than 100 patients. Neither HMO had established limits on liability that would adequately protect the subcontractors from major losses. As noted on page 19, Med Care's subcontractors also pay their primary care physicians on a capitation basis.

Contracting Requirements Incorrectly Interpreted

HHS said that we incorrectly interpreted the federal regulation requiring subcontractors to fulfill the contracting requirements that are appropriate to the services or activities delegated under the subcontract. HHS noted that the regulations are silent regarding specific services or activities, but said that it interprets the regulations as applying the financial solvency and minimum enrollment requirements to the HMO as opposed to the subcontractor. Specifically, HHS said:

- The requirement for each provider subcontractor to provide proof of financial responsibility or insolvency is not appropriate if (1) the HMO has satisfied the contract provision, which requires proof of provision against the risk of insolvency, that is, financial reserves and reinsurance provisions adequate to the state and the Secretary or (2) the provider subcontractors agree in writing not to make Medicaid enrollees liable for the HMO's debt if the HMO becomes insolvent.

- If the HMO has satisfied the 75/25 minimum enrollment requirement with its aggregate enrollment, the requirement for the provider subcontractor to maintain a 75/25 enrollment composition is not appropriate.

Although Medicaid regulations give HHS wide discretion to determine which contracting requirements are appropriate to include in subcontracts, we continue to believe that HHS should mandate that risk-based contractors entering into risk-based subcontracts be required to include provisions requiring subcontractors to prove their financial solvency, develop a plan for dealing with insolvency, and enroll a specified percentage of private members.

A contracting HMO is not responsible for the debts of its subcontractors, which are independent and distinct legal entities. Therefore, it is illogical, in our opinion, to assert that, if the HMO has satisfied the contractual requirement for proof of provision against risk of its insolvency, there is no need to be concerned with the possible insolvency of subcontractors.

The fact that the HMO is required to make provisions against risk of its insolvency is no consolation to the creditors of the HMO's subcontractors. A subcontractor that finds it difficult to pay its bills may also find it is increasingly difficult to provide quality care to its enrollees.

Similarly, if the subcontracts were on other than a risk-comprehensive basis, we could see merit in applying the patient mix requirement only to the HMO. However, we see no logical reason to combine patient mix statistics from a group of unrelated, independent prepaid health plans over which the HMO has no direct control. For example, the Chicago HMO subcontracts contain no provision even requiring the medical group to accept Medicaid enrollees. If the subcontracts were not on a risk basis, or if the capitation covered only primary care services, it might be appropriate to waive the patient mix requirement as allowed by the regulations.

In summary, not requiring that contractual requirements pertaining to financial solvency and patient mix be inserted into risk-comprehensive subcontracts poses the danger of diminished quality of care available to Medicaid recipients.

Illinois Comments and Our Evaluation

Illinois (see app. III) said that it believes the Chicago-area HMOs are currently in compliance with federal regulations requiring subcontractors to comply with those contracting requirements appropriate to their services or activities. The only services delegated under the subcontracts are, Illinois said, the provision of medical services. The financial and patient-mix requirements of federal regulations are, Illinois said, the responsibilities of the HMOs, not the subcontractors; requiring every clinic in Chicago willing to accept Medicaid clients to have 25 percent private pay enrollees would devastate access to care in impoverished areas. Illinois said that the federal regulation does not apply to individual clinics and it is not aware of any state that applies these requirements to individual clinics.

As discussed above, when an HMO transfers most of the risks for the cost of Medicaid recipients' health care to subcontractors functioning essentially as mini-HMOs, those subcontractors should be required to meet the appropriate contracting requirements that apply to the HMO. We can see no logical reason to allow HMOs to subcontract on a risk basis without assurance that the subcontractor is financially capable of assuming the amount of risk transferred.

We recognize that HHS has not interpreted the financial solvency and patient-mix requirements as applying to subcontractors. We have, therefore, changed our recommendation to the Congress to suggest that the Congress require HHS to apply the two requirements to subcontractors.

Finally, implementation of our recommendation relating to patient mix would not, as Illinois states, require every clinic in Chicago willing to accept Medicaid clients to have 25 percent private pay enrollees. The requirement would apply only to those clinics subcontracting on a capitation basis to provide services to Medicaid recipients. The requirement would not apply to clinics providing services on a fee-for-service basis and could be waived by the Medicaid agency for HMO subcontractors that have contracts that are not risk comprehensive. Although Chicago HMO and Med Care use risk-comprehensive contracts with their provider groups, they could avoid the patient-mix requirements by decreasing the amount of risk transferred to their subcontractors.

Recommendation to the Congress

Different requirements for risk-based contracts have been established for HMOs and other prepaid health plans participating in the Medicare and Medicaid programs. The Medicare law establishes a minimum enrollment requirement in order to ensure that HMOs have enough members to

spread the risk; the Medicaid law and regulations are silent. Medicaid regulations require risk-based subcontractors to meet those risk-based contracting requirements appropriate to the services being subcontracted; as we first pointed out in a July 16, 1986 report,⁹ the Medicare law and regulations are silent. We believe both requirements have merit and should apply to both programs. Accordingly, we recommend that the Congress amend the Social Security Act to (1) establish a minimum enrollment requirement for HMOs participating in the Medicaid program and (2) require risk-comprehensive subcontractors serving Medicaid recipients and/or Medicare beneficiaries to meet the minimum enrollment requirement as well as risk-based contracting requirements relating to patient mix and financial solvency.

⁹Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986), pp. 46-54.

Mechanisms to Identify Quality-of-Care Problems Inadequate

HCFA, IDPA, and the Chicago-area HMOs have not established effective mechanisms to identify and correct potential underservicing and other quality-of-care problems. Specifically,

- the Chicago-area HMOs have made limited progress in developing quality assurance programs to monitor providers' quality of care;
- adequate utilization data were not gathered and analyzed to detect potential underservicing; and
- external peer reviews have focused on the quality of the services that were provided, but have not focused on whether the number of services provided were inappropriately reduced.

Chicago-Area HMOs Limited Progress in Developing Quality Assurance Programs

Although required by federal regulations to have quality assurance programs, the Chicago-area HMOs have made limited progress toward developing such programs. The HMOs' quality assurance programs look primarily at the use of hospital services. IDPA has not, however, completed follow-through to ensure that these HMOs develop effective programs.

Quality Assurance Programs Required in HMOs

Contracts between IDPA and HMOs require that HMOs have quality assurance programs. The contracts specify that HMO quality assurance programs must include

- an evaluation of the methods for providing medical services, as well as the outcome of outpatient and inpatient services;
- procedures for correcting deficiencies found in patient care; and
- a process for educating providers and assuring that deficiencies are corrected.

Crescent Counties Finds Quality Assurance Programs in Chicago-Area HMOs Seriously Deficient

Crescent Counties, through its subcontractor, Health Shared Management Services,¹ found the quality assurance programs of the Chicago-area HMOs seriously deficient. In its April 1, 1987, report, Health Shared gave the quality assurance programs of the seven HMOs reviewed—American, Anchor, Chicago HMO, Compass, Illinois Masonic, Med Care, and Mile Square—an average rating of 6.39 out of a possible 100; scores ranged from 1.75 for Anchor to 13.25 for Chicago HMO.

¹An independent review organization specializing in quality assurance work.

Health Shared reported that HMO efforts focused primarily on utilization review, looking at quality issues only as identified through hospital utilization review. Health Shared also reported that HMOs lacked effective (1) systems for gathering and evaluating utilization data, (2) processes to assure appropriate follow-up and resolution of problems, and (3) on-site evaluations of providers' medical care services and patient outcomes.

The following were among the specific findings in the Health Shared report:

- "The HMO [Compass] depends entirely on its provider sites for credentialing and privileging. It does not evaluate this credentialing and privileging process."
- "No quality assurance monitoring systems exists [at Anchor] nor a formal or consistent mechanism for applying quality screens for inpatient or outpatient care. Presently the only system in place is that of perception."
- "In addition to quality issues being identified informally through the U.R. [utilization review] process, the HMO [Med Care] relies on the thickness of the record or the Director of Quality Assurance's memory to identify potential problems."

The vice president of Health Shared said that the HMO quality assurance programs were so fragmented that HMOs could not assure that Medicaid recipients were receiving quality medical care. Following issuance of the Health Shared report, Chicago HMO contracted with Health Shared to help it develop a better quality assurance plan.

HCFA Finds Quality Assurance Programs Inadequate

In a review completed in May 1987, HCFA also identified serious inadequacies in (1) some of the Chicago-area HMOs' quality assurance programs and (2) oversight of those programs by IDPA. Its files for the four HMOs reviewed contained quality assurance plans, but no evidence that IDPA had reviewed or approved the plans. For three of the four HMOs, plans functioned primarily as utilization review programs to control hospital admissions and lengths of stay. Few, if any, outpatient services were reviewed for quality of care or patient outcomes. The fourth HMO (Chicago HMO) had implemented an extensive review program, which included checking random samples of patient charts for completeness and adequacy during site visits to physician offices.

Finally, part of utilization review was to ensure that the HMOs had taken appropriate follow-up action. But IDPA had no documentation establishing that it had tracked problems identified or recommendations made.

In response to HCFA's findings, IDPA revised procedures for (1) reviewing HMOs' quality assurance, utilization review, and peer review programs and (2) notifying HMOs of the results of its reviews. IDPA also developed corrective action plans for each HMO to strengthen quality assurance plans; IDPA included those plans in the fiscal year 1988 contracts. IDPA agreed to revise the contract compliance audit guide to determine and report the status of corrective actions resulting from recommendations based on the HMOs' quality assurance programs.

Ineffective Follow-Up on Corrective Action Plans

Although HMOs were required to submit to IDPA corrective action plans, strengthening their quality assurance programs, no later than November 1987, IDPA was unable to provide documentation that three HMOs (Med Care, Mile Square, and American) responded to the requirement. Med Care, however, submitted a revised quality assurance plan in October 1987. Other than comments on Chicago HMO's revised quality assurance plan, IDPA records contained no evidence that the corrective action plans or revised quality assurance plans submitted had been reviewed.² IDPA's supervisor of Medical Audits and Quality Assurance said he read the plans submitted to determine whether they encompassed Health Shared's recommendations; if the plans had not been acceptable, the HMOs would have been notified. To his knowledge, no such letters were sent.

IDPA's 1988 audits for contract compliance did not test compliance with Health Shared recommendations. Like the 1987 compliance audits, the 1988 ones did not assess the effectiveness of the quality assurance programs. The medical audits supervisor told us that IDPA set up a quality assurance group to determine, among other things, whether the HMO quality assurance programs complied with the recommendations. The quality assurance staff was hired a year later than projected; its assessment of compliance with the contract provisions relating to quality assurance programs was not done until 1989. IDPA also had a peer review organization review the HMO quality assurance programs during

²In commenting on a draft of this report, IDPA submitted comments on an October 1988 revision to Med Care's quality assurance plan, but the comments did not address compliance with the Health Shared recommendations. IDPA was unable to identify any comments on the October 1987 revisions.

1989. As of May 1990, reports on the results of the two reviews had not been completed.

Utilization Data Inadequate

Utilization data—information on medical services provided to HMO enrollees—can indicate whether too many or too few services are being provided. But adequate data are not being collected. This is because

- medical records do not fully document the services provided, and the HMOs generally do not have methods for systematically collecting utilization data;
- HMOs have generally submitted incomplete and inaccurate utilization data to IDPA;
- IDPA has not set expected utilization criteria for evaluating the completeness of data submissions and the performance of individual HMOs and providers; and
- HCFA has not (1) required states to include utilization data in their MMISS and (2) developed standards for utilization reporting for such systems.³

Poor Documentation in Medical Records

Both Crescent Counties (in its 1987 and 1988 peer reviews of the Chicago-area HMOs) and IDPA (in its 1987 and 1988 compliance audits) identified serious deficiencies in the maintenance by Chicago-area HMOs of Medicaid recipients' medical records. Crescent Counties found that HMOs generally lacked effective systems to generate medical care utilization data, adversely affecting their ability to monitor the quality of care given by their physicians.

Medicaid regulations (42 C.F.R. 434.6(a)) require that contracts must provide that HMOs maintain an appropriate record system for services provided to enrollees. These records must be adequate to enable the state Medicaid agency and HCFA to evaluate, through inspection or other means, the quality, appropriateness, and promptness of services.

IDPA contracts with the HMOs require them to provide specified preventive health services. IDPA's compliance audits test compliance with those requirements. Significant problems in HMO maintenance of patient medical records were identified in both the 1987 and 1988 audits. For example, the percentage of records that did not contain evidence of the required

³That is, automated systems to process Medicaid claims as well as retrieve and produce utilization and management information about Medicaid services.

- periodic physical examination record was 76 percent in 1987 and 87 percent in 1988,
- immunization record was 56 percent in 1987 and 1988, and
- growth charts for pediatric cases was 64 percent in 1987 and 57 percent in 1988.

Crescent Counties' 1987 review of approximately 3,500 enrollees' medical records from eight Chicago-area HMOs—American, Anchor, Chicago HMO, Compass, Illinois Masonic, Med Care, Metro Care, and Mile Square—encompassed about 19,000 ambulatory care visits. About 4,100 documentation problems were referred by nurse-reviewers to physician-reviewers. Physician-reviewers confirmed about 3,100 instances in which the care provided was inadequately documented. Similar problems were identified in the 1988 Crescent Counties review; nurse-reviewers assessed about 14,400 ambulatory care visits to the Chicago-area HMOs and referred about 14,000 documentation problems to physicians for assessment of the potential effect on quality of care.

The likelihood that these problems may relate to lack of appropriate care varied by HMO, however. For example, although an average of one documentation problem was found on each medical record reviewed at Anchor, physicians were able to find other documentation indicating that the care was appropriate during all but 1.9 percent of the visits reviewed. Documentation problems at Compass, however, were so severe that the physicians were unable to determine the appropriateness of care provided for 72.6 percent of the visits reviewed. At Compass, an average of four documentation problems were identified in each medical record reviewed. Like Compass, Med Care had multiple documentation problems (an average of over two per visit reviewed), and physician reviewers were unable to find other documentation to demonstrate the appropriateness of the care given during 34.0 percent of the visits reviewed.

In its reports, Crescent Counties expressed concern about the impact the lack of documentation could have on the quality of care provided by the HMOs. For example, the 1987 report stated, the promptness and appropriateness of care cannot be determined without complete documentation of symptoms, tests performed and their results, diagnoses, and treatments prescribed. Similarly, the 1988 report stated, poor documentation can affect continuity of care when enrollees change physicians; if information necessary for the ongoing care and treatment of the patient is not in the medical record, the ability of the new physician to make appropriate and prompt treatment decisions may be impaired.

As part of its 1987 review, Crescent Counties subcontracted with Health Shared to evaluate, among other things, the ability of HMOs to generate utilization data. Health Shared reported that the data generation and information systems of all seven HMOs reviewed were seriously deficient; individual scores ranged from 0 points out of 100 possible for four HMOs to 25 at Chicago HMO. IDPA has not completed follow-up to ensure that Chicago-area HMOs improve their medical utilization records.

Accuracy and Completeness of Data in Utilization-Reporting System Questionable

IDPA implemented an automated utilization-reporting system in July 1986, but has done little to test the completeness and accuracy of the data being submitted. Although IDPA has assessed about \$690,000 in penalties for HMOs, these were assessed for late submissions or submissions that failed computer edits. IDPA has not, however, reported on its efforts to trace the data reported by the HMOs back to the medical records to determine the completeness of the data accepted or the consistency of the data submitted.

Medicaid regulations (42 C.F.R. 456.23) require that the state Medicaid agency have a postpayment review process that allows state personnel to develop and review

- profiles of recipients' utilization of medical services,
- profiles of the services provided by individual physicians and other health care providers, and
- criteria for identifying recipients and physicians whose use of services exceeds some norm (exception criteria, that is, the identification of exceptions to expected utilization of services so that the agency can take action to change the utilization practices of recipients and physicians).

In 1985, IDPA began developing an automated system to collect medical utilization data from HMOs.⁴ For the fiscal year beginning July 1, 1986, IDPA contracts with the Chicago-area HMOs required IDPA to submit quarterly computer tapes with utilization data on services provided; financial penalties were included in fiscal year 1987 contracts for late or unacceptable tapes.

IDPA has assessed and collected penalties from each HMO for failing to submit acceptable utilization tapes promptly. IDPA had assessed penalties totaling \$690,000, as of December 1988. At that time, only about

⁴Before July 1986, HMOs were required to submit only limited data on the number of services provided.

Chapter 3
Mechanisms to Identify Quality-of-Care
Problems Inadequate

30 percent of the tapes submitted had been accepted. Frequently, a tape would be submitted repeatedly until it fell within acceptable error limits. IDPA officials told us that about 40 percent of the tapes submitted by HMOs had been accepted by IDPA as of December 1989. In commenting on a draft of this report, Illinois stated that acceptable fiscal year 1989 utilization data have been obtained from all Chicago-area HMOs. IDPA's manager, Prepaid Health section, told us that at least one acceptable data tape has been obtained from each HMO for each quarter of fiscal year 1989. He did not know, however, whether additional tapes should have been submitted.

IDPA officials said the HMO data tapes are now more accurate, but not all of the services are being reported. Because financial damages are only assessed if the data are submitted late or if the data submitted are inaccurate, HMOs have incentives to submit only the data they are reasonably sure is accurate.

Despite wide variation in the number of reported services per HMO enrollee (see table 3.1), IDPA has not reviewed medical records at HMOs to test the accuracy and completeness of reporting or to determine if what should be reported as "a service" is interpreted consistently. During the 1989 compliance audits, IDPA officials, to test accuracy, traced a sample of the reported services back to the medical records. Although the reports had not been completed as of May 15, 1990, the manager, Prepaid Health section, said that about 60 percent of the services checked at Illinois Masonic had problems; similar problems were found at most of the other HMOs. IDPA officials have no plans to examine a sample of medical records to determine the completeness of utilization reporting.

Table 3.1: Services Per Enrollee (July 1987-Sept. 1988)

HMO	Services reported ^a			Monthly average		
	7/87-12/87	1/88-6/88	7/88-9/88	Services	Enrollees	Services per enrollee
American	3,156	3,487	1,417	537	2,601	.21
Anchor	5,068	4,568	1,902	769	1,600	.48
Chicago	89,210	73,607	23,831	12,443	67,692	.18
Compass	708	588	273	105	2,008	.05
Illinois Masonic	12,199	4,319	5,290	1,454	1,605	.91
Med Care	37,631	24,763	43,763	7,044	23,088	.31
Mile Square	28,598	11,105	^b	3,309	5,210	.64

^aIncludes only those services accepted as of December 9, 1988.

^bDropped out of program in June 1988.

**Criteria for Expected
Utilization Not Set**

To assess the appropriateness of the types and numbers of services provided, states generally compare reported utilization with some criteria defining expected utilization. Such criteria might, for example, set expectations for

- the percentage of enrollees obtaining services over a certain period of time,
- the frequency of certain procedures,
- the number of hospital admissions, and
- the number of referrals to specialists.

Under a fee-for-service payment system, providers whose utilization practice greatly exceeded such expectations might be investigated to determine whether they were providing medically unnecessary services or submitting fraudulent bills for services not provided. Under a prepaid health program, an HMO or individual physician whose utilization practices are significantly below expected levels should, in our opinion, similarly be investigated to determine whether medically necessary care is being provided to Medicaid enrollees. As of January 1990, IDPA had not established criteria to be used in evaluating utilization under a prepaid health program.

**Prepaid Health Program
Utilization Excluded From
MMISs**

Each state must establish and maintain an MMIS to, among other things, identify abusive or fraudulent practices by beneficiaries and providers. As of January 1990, however, HCFA had not required states to include, in their MMISs, services provided to Medicaid recipients enrolled in HMOs and other prepaid health programs.

The Mental Health Systems Act (P.L. 96-398) required most states, including Illinois, to have an MMIS meeting federal standards by September 30, 1982 (subsequently extended to 1985), or face reductions in federal funding of program administrative costs. HCFA standards require that each state establish a Surveillance and Utilization Review Subsystem (SURS) of MMIS to help identify abusive or fraudulent practices by beneficiaries and providers. Specific criteria have been established for certification of SURS. These criteria, however, address only utilization data generated through the traditional fee-for-service system.

Because the incentives under a fee-for-service system are to overuse services so as to increase reimbursement, SURS is directed primarily toward detecting unnecessary services. In a prepaid health program, however,

physicians have opposite incentives. They receive a fixed monthly payment and realize profits or losses depending on their costs for providing the services covered under the contract. Accordingly, SURS for a prepaid health program should, in our opinion, be directed toward detecting underservicing. In other words, SURS should focus on identifying providers who are providing fewer medical services, making fewer referrals to specialists, or authorizing fewer hospital admissions than their peers. As of January 1990, however, HCFA had not (1) established criteria for including prepaid health program data under SURS and (2) required that utilization data from Medicaid recipients enrolled in prepaid health programs be included in MMIS. HCFA officials said that they are still trying to determine what prepaid health data should be required for inclusion in MMIS.

Peer Review Does Not Focus on Underservicing

Despite indications that unexpectedly large numbers of HMO enrollees were receiving no services from their HMOs, IDPA has not followed up to determine the extent to which the enrollees (1) obtained services that were not documented in their medical records, (2) had been denied needed medical care, and (3) had no need for services or were disenrolled before needing care. IDPA did not require Crescent Counties to determine why a large number of enrollees received no services. Until such an assessment is done, we cannot know the extent to which the problems identified were caused by underservicing or the failure to document services that were provided.

Although IDPA's 1987 compliance audits found that 57 percent of enrollees sampled at five Chicago-area HMOs had no record of having received services from their HMOs, IDPA did not ask Crescent Counties to find out why. In 1987, Crescent Counties selected a sample of Medicaid recipients from enrollment records. The 30 percent of enrollees who had no record of services were not reviewed; Crescent Counties had expected all but 10 percent of enrollees to have obtained care. The 1988 Crescent Counties review focused strictly on Medicaid recipients who had obtained care from an HMO; enrollees with no record of having obtained care were excluded because the sample of medical records was drawn from the utilization data submitted to IDPA by the HMOs. Medicaid recipients who had not received services were excluded for economic reasons; it did not make sense, IDPA officials said, to pay Crescent Counties to review records when there was no indication of services having been provided.

Crescent Counties reviewed records pertaining only to actual recipients of services, based on IDPA's interpretation of the provision in OBRA-86, requiring an independent review of the "quality of the services furnished under each contract." HCFA has not promulgated rules interpreting this provision. In the absence of such guidance, we would agree that IDPA's interpretation appears reasonable. However, failure to provide needed medical care to eligible enrollees may, in itself, constitute poor quality services. Therefore, in our view, HCFA may reasonably interpret this provision more broadly, to include an assessment of whether needed medical services are being provided to all potential recipients. Interpretive rules to this effect would require IDPA to, in turn, require peer review organizations to include in their review an assessment of potential underservicing.

Because of the incentives to inappropriately delay or reduce services to HMO recipients, discussed in chapter 2, we believe a primary focus of the evaluation by the peer review organization should be on determining whether needed services are provided promptly.

Conclusions

Effective mechanisms to identify and correct potential underservicing and other quality-of-care problems do not exist for the Chicago-area HMOs. HCFA and IDPA have not effectively followed up to ensure that the HMOs develop quality assurance programs to monitor the care they provide and correct deficiencies identified. An important component of a quality assurance program is the maintenance of adequate documentation for the medical services provided. Because utilization data are also an essential component in IDPA and HCFA oversight of the HMOs, it is important that actions be taken to improve the accuracy and completeness of the utilization data being reported. Finally, guidelines for external peer reviews should be developed that require an assessment of potential underservicing.

Recommendations to the Secretary of HHS

We recommend that the Secretary, through the Administrator of HCFA, direct IDPA to

- review the accuracy and completeness of medical care utilization data and take necessary steps to improve utilization reporting and
- establish criteria for expected utilization and develop screens to detect possible underservicing by physicians, medical groups subcontracting with HMOs, and HMOs.

We also recommend that the Secretary (1) develop standards for utilization-reporting systems for prepaid health systems and (2) require states to include such reporting systems in their MMIS. Finally, we recommend that the Secretary develop guidelines for peer review organizations to use in reviews of HMOs and other prepaid health programs that require an assessment of potential underservicing of Medicaid recipients.

HHS Comments and Our Evaluation

Authority to Impose Penalties

HHS said that it lacks statutory authority to require states to specifically assess financial penalties for inaccurate and incomplete data. HHS said that although it has authority to impose civil monetary penalties on Medicaid HMOs, it does not extend to penalties for data problems. HHS also said it is uncertain whether HHS has the authority to direct IDPA to establish criteria for expected utilization or to develop screens to detect possible underservicing. Given the absence of direct authority, HHS said, it has previously recommended that the HCFA regional office work with the state to correct identified quality assurance program inadequacies. HHS will further recommend, it said, that the HCFA regional office work with the state to improve the state's general oversight and follow-up efforts.

We have revised the recommendation to indicate that HHS should require the state to take necessary steps to improve utilization reporting. Title XIX of the Social Security Act requires states to establish utilization-reporting systems, evaluate the appropriateness of the utilization of services, and ensure that quality care is provided. We believe the act gives HHS sufficient authority to require a state to establish criteria by which its compliance with these requirements can be assessed.

MMIS for Prepaid Health Plans

HHS said that it would be worthwhile to examine how underutilization may be detected, possibly leading to the development of quality assurance and utilization review specifically for Medicaid prepaid health plans. This could, HHS said, include protocols to monitor underutilization of medical services. HHS said, however, that it does not believe that MMIS are appropriate for managing Medicaid's involvement with prepaid

plans. Rather, HHS said, smaller, more flexible systems specifically designed for this purpose should perform this important function, and summary statistics from these subsystems could then be integrated into MMISS.

Illinois receives enhanced federal funding for its utilization-reporting system, as part of its MMIS, an Illinois official told us. Continued enhanced federal funding should not, in our opinion, be provided to states for developing utilization-reporting systems for prepaid health systems unless those systems are to meet the MMIS requirements established under the Mental Health Systems Act.

Aside from the financing issue, we note that HHS's comments are a step back from prior statements. HCFA officials previously told us that they are developing standards for a prepaid health subsystem for MMISS. As recently as January 1990, we were told that they were still trying to determine what data to include in the prepaid health subsystem of MMISS. The current comments, however, merely indicate that "it would be worthwhile to examine" how underutilization might be detected. HHS outlines no steps and sets no timetable.

Guidelines for Peer Reviews

HHS did not comment on our recommendation that it develop guidelines for peer review organization reviews of HMOs.

Illinois Comments and Our Evaluation

Illinois said that it believes that the utilization data reported by each HMO are accurate, but will review the issue with HCFA. Illinois also said that it will formalize and document the "unofficial" criteria it currently has for determining expected utilization.

Although the reporting of utilization data has improved to the point where IDPA has obtained at least one acceptable data tape from each HMO for each quarter of fiscal year 1989, IDPA still does not know how complete the data submissions are. This is because IDPA lacks adequate criteria for expected utilization. The "unofficial" criteria IDPA referred to in its comments are limited to (1) comparing services with the minimum standards of care set out in the contracts with the HMOs, (2) looking to see if there is at least one encounter per member, and (3) comparing rates of inpatient utilization. The manager of IDPA's Prepaid Health section agreed that better criteria are needed; he said that the section is

writing to a consultant for help in establishing criteria, but such criteria will not be established before fiscal year 1991.

In addition to the lack of criteria, IDPA's efforts have focused on the accuracy of the data submitted, not on the completeness of that data. As shown in table 3.1, the HMOs vary widely in the volume of services reported per enrollee. Neither Crescent Counties nor IDPA's quality assurance staff, however, are assessing whether there are services documented in the medical records that are not being reported by the HMOs.

Matter for Congressional Consideration

Establishing effective utilization-reporting systems for HMOs and other prepaid health plans, including screens for detecting underservicing, are of critical importance in ensuring that Medicaid recipients obtain needed services. Further, the lack of effective utilization reporting prevents an assessment of the effects of financial incentive arrangements on quality of care. Finally, this lack tends to limit the ability of peer review organizations to effectively evaluate the quality of care provided by HMOs.

Because HHS has no specific plans or timetable for improving utilization-reporting systems, the Congress may wish to consider (1) requiring HHS to develop criteria and screens for prepaid health systems and (2) set a deadline for completion.

IDPA Should Take Action on Potential Quality-of-Care Problems

IDPA has not taken effective follow-up action after potential quality-of-care problems are identified during compliance audits or other reviews. For example, IDPA has not determined

- why over 58,000 Medicaid recipients voluntarily disenrolled from the HMOs over a 3-year period,
- whether the reason that only a limited number of children's preventive health services are included in medical records is poor documentation of services provided or underservicing,
- whether pregnant women are obtaining prenatal care appropriate to their medical condition, and
- why required consent forms are not documented in the medical records of some Medicaid recipients obtaining sterilizations or hysterectomies.

IDPA did not establish a quality assurance group until July 1988; in August 1988, the group started doing medical record reviews to follow up on potential quality-of-care problems. The group, however, has not attempted to determine whether the problems previously identified through the compliance reviews and peer reviews were caused by failure to (1) adequately document the services provided or (2) provide needed services.

No Survey Done to Determine Causes of High Voluntary Disenrollments

Reducing or delaying medical care could lead to (1) widespread enrollee dissatisfaction and (2) disenrollment from the HMOs. Despite continuing high rates of voluntary disenrollments from the Chicago-area HMOs, IDPA has not carried out, nor required the HMOs to carry out, patient satisfaction surveys to determine the reasons.

Medicaid recipients can voluntarily disenroll from a Chicago-area HMO and return to the fee-for-service system at any time. During fiscal years 1986-88, over 58,000 Medicaid recipients voluntarily disenrolled from the Chicago-area HMOs (see table 4.1). As shown in table 1.1 (p. 12), total enrollment of Medicaid recipients in the Chicago-area HMOs was about 88,000 in January 1989.

Table 4.1: Voluntary Disenrollments From Chicago-Area HMOs (Fiscal Years 1986-88)

HMO	Disenrollments			Total
	1986	1987	1988	
American	821	2,249	616	3,686
Anchor	101	135	72	308
Chicago	7,109	12,344	9,038	28,491
Chicago Care	119	^a	^a	119
Compass	10	828	794	1,632
Illinois Masonic	312	402	403	1,117
Med Care	5,544	7,484	4,741	17,769
Metro Care	1,782 ^b	^b	^b	1,782
Mile Square	992	1,445	805	3,242
University of Illinois	•	6	•	6
Total	16,790	24,893	16,469	58,152

^aChicago Care dropped out of the program in January 1987.

^bMetro Care dropped out of the program in March 1987. Its Medicaid enrollees were acquired by Chicago HMO.

When disenrollment is voluntary, it tends to be, according to a 1987 study of Medicaid recipients in Chicago-area HMOs, because of dissatisfaction with the services provided. The study included a recommendation that further research be done to determine the reasons for voluntary disenrollments.

IDPA officials told us that a good way to arrive at the reasons recipients voluntarily disenroll is by a patient satisfaction survey; a provision in the HMOs' fiscal year 1988 contracts required them to do such surveys. However, IDPA subsequently planned to do one combined survey instead of having the HMOs conduct separate surveys. According to IDPA officials, the survey was not conducted; the envelopes were stuffed and ready to be mailed when officials were told to discontinue the project. IDPA officials told us, in January 1990, that they still plan to conduct a survey, but have not established specific deadlines. The officials did not recall why the earlier project had been discontinued.

Follow-Up Needed to Determine Availability of Preventive Health Services for Children

IDPA requires Chicago-area HMOs to provide a wide range of health screening, immunizations, and other services to Medicaid recipients under 21 years of age. But IDPA's compliance auditors reviewed the HMOs and found little documentation that an adequate level of preventive health services was being provided. Crescent Counties' and IDPA's quality assurance staffs determined that documentation problems at some Med Care sites were significant. Crescent Counties reported that

documentation problems could be indicative of quality-of-care problems. Further action is needed to determine whether the services are (1) being provided but not documented in the medical records or (2) not being provided.

Contract Requirements

Contracts between IDPA and the Chicago-area HMOs stipulate that all patients under 21 years of age should receive screening examinations and appropriate immunizations at intervals, as specified by the Healthy Kids program. Under this program—a required component of Illinois's Medicaid program¹—Medicaid-eligible people under 21 years of age are entitled to receive

- a series of 13 periodic health screenings, scheduled at designated times between birth and 20 years of age;
- immunization against childhood illnesses, including diphtheria, tetanus, pertussis, polio, measles, rubella, and mumps;
- elective screening procedures, depending on the age of the child or the physician's judgment or both; and
- follow-up diagnosis and treatment of any defect or abnormal condition identified during screening.

IDPA required that Healthy Kids screening forms be submitted to them to document the services provided.

Compliance Audits Find Few Documented Healthy Kids Services

IDPA found little evidence in its 1987 and 1988 compliance audits that the services for children, as specified in Healthy Kids, were being provided. In 1987, auditors found Healthy Kids forms in the medical records of only 14 of the 330 children whose records were reviewed. Chicago HMO complained that the finding was misleading because (1) services may have been provided but not documented on the Healthy Kids forms and (2) copies of the forms were not required to be in the medical records. In response, IDPA, in the 1988 compliance audit, looked for other evidence that Healthy Kids services were being provided. Specifically, IDPA auditors reviewed the medical records to determine whether there was (1) any reference to participation in Healthy Kids or (2) other documentation of provision of services required by the program and required

¹The Healthy Kids program is Illinois's version of the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, required to promote health care for Medicaid recipients under 21 years of age.

by IDPA to be reported. As shown in table 4.2, the auditors found no indication that complete Healthy Kids services had been provided to 677 of the 815 Medicaid recipients under 21 years of age.

Table 4.2: Chicago-Area HMO Compliance With Healthy Kids Requirements (1988)

HMO	Medical records reviewed	Healthy kids requirements	
		Met	Not met
American	59	1	58
Anchor	60	0	60
Chicago	401	92	309
Compass	30	0	30
Illinois Masonic	74	7	67
Med Care	80	30	50
Mile Square	111	8	103
University of Illinois	^a	^a	^a
Total	815	138	677

^aResults not reported because only two medical records were reviewed

IDPA recommended specific action against one HMO—Compass—stating that Compass should be notified in writing of the deficiency, reminded that the deficiency was brought to its attention in 1987, and required to provide a written plan of correction. In a June 30, 1988, letter, the president of Compass responded that Compass will (1) reeducate physicians about the Healthy Kids reporting requirements and (2) ensure that an adequate supply of reporting forms are available at each Compass site. The compliance auditors also recommended that IDPA periodically (1) do chart reviews to determine compliance with the Healthy Kids program requirements and (2) consult the Healthy Kids program to determine the degree to which HMO enrollees were participating and the reporting requirements were being met. When we asked whether chart reviews were conducted, the supervisor of Medical Audits and Quality Assurance told us, in May 1989, that because of a lack of resources, no chart reviews had been conducted at Compass or the other HMOs to determine compliance. In commenting on a draft of this report, Illinois said that chart reviews have now been conducted.

Crescent Counties Finds Serious Documentation Problems at Med Care

Crescent Counties' 1987 and 1988 reviews of Med Care identified serious documentation problems in the medical records of children 6 years of age.² In its 1987 report, Crescent Counties said that the problems appear to be spread across the majority of HMO sites and may reflect a general problem in profiling the well-child care performed. The specific problems cited were frequency of legibility problems, missing physician signatures, and questions about medical history and physical documentation. The 1988 Crescent Counties review found similar problems.

On January 18, 1989, the chief of IDPA's Bureau of Medical Practitioner Services notified Med Care of the 1988 Crescent Counties findings: For children 6 years of age and under, Med Care had a greater-than-average number of questions, raised by nurse reviewers, concerning the adequacy of immunization status as well as growth and development charts; of all HMOs reviewed, Med Care also had the highest (14 percent) number of questions raised about completed charts for children under 1 year of age.

Quality Assurance Staff Confirm Documentation Problems at Med Care

To follow up on Crescent Counties' findings, in February 1989, IDPA's quality assurance staff reviewed medical records for a sample of 115 recipients at four Med Care sites. The reviews confirmed the findings—the documentation of preventive health services provided was seriously deficient. The quality assurance reviews did not attempt, however, to follow up with recipients or providers to determine whether the needed services were provided but not documented or never provided.

In commenting on a draft of this report, Illinois stated that IDPA initially targeted chart reviews at HMO sites identified as notably deficient in the 1988 Crescent Counties report, but subsequently began doing chart reviews for all remaining HMO sites. These reviews involved, Illinois stated, on-site inspections to determine the cause and extent of any clinical management, documentation, or quality assurance coordination problem.

²The 1987 review identified significant documentation problems at all but Mile Square HMO, but cited American as having problems that could indicate poor quality. The 1988 review found a relatively low rate of documentation problems at the other HMOs.

Appropriateness of Prenatal Care Not Adequately Assessed

Efforts to assess the adequacy and appropriateness of prenatal care provided by the Chicago-area HMOs have been slow or limited or both. Specifically,

- compliance audits have not adequately addressed compliance with contract requirements relating to prenatal care;
- Crescent Counties assessed the adequacy of prenatal care provided by three HMOs (identifying problems at one), but did not assess the adequacy of care provided by the other four HMOs;³ and
- quality assurance staff did medical record reviews at selected Med Care provider sites in early 1989 to follow up on Crescent Counties' findings and, subsequently, began a broader investigation of Med Care and other HMOs.

Compliance With Contract Requirements Not Adequately Tested

Contracts between IDPA and the Chicago-area HMOs include a series of requirements intended to help ensure that pregnant women obtain quality care. According to the contracts, HMOs must, at a minimum, provide and document

- a comprehensive prenatal evaluation as well as care, both in accordance with standards published by the American College of Obstetrics and Gynecology;
- a nutrition care plan documenting the nutritional assessment and counseling provided;
- counseling and patient education as to the health risks of obesity, smoking, alcoholism, and improper nutrition during pregnancy; and
- the identification of high-risk mothers or infants or both who need consultations or referrals during which appropriate physicians at a level III perinatal center will determine patient management.⁴

In IDPA's guidelines for compliance audits, steps are included to determine whether (1) prenatal care was documented in the records of pregnant enrollees; (2) perinatal and neonatal cases were identified in the records, appropriate referrals made, and follow-up services and information presented in the patient record; and (3) health education and counseling information were documented in the records. The audit

³The four HMOs had too few cases for meaningful analysis, Crescent Counties stated.

⁴Illinois has a regional perinatal system to (1) facilitate early identification and referral to special level III perinatal centers for potentially high-risk mothers and (2) provide coordinated follow-up care to high-risk newborns. Under the system, a community hospital or other provider that identifies a pregnant woman as potentially high-risk should refer her to a level III center. This center is to provide or coordinate any outpatient, home care, or other follow-up services for both mother and infant.

reports for 1987 and 1988, however, did not address compliance with these requirements.

IDPA's supervisor of the Medical Audits and Quality Assurance section told us that the steps were carried out as part of broader assessments of compliance with minimum record and health education requirements. The audit reports identified significant problems at each HMO with respect to compliance with minimum record and health education requirements. Because the reports do not specifically address prenatal care, the extent of these prenatal care problems is unknown. In addition, quality or appropriateness of the services provided were not assessed under the records review.

During the 1989 compliance audits, quality assurance staff assessed the adequacy of prenatal care. The supervisor told us these staff were more qualified than compliance auditors to review prenatal care because of their medical background.

Prenatal Care Examined in Crescent Counties Review

Crescent Counties examined the prenatal care obtained by 62 high-risk pregnant women enrolled in three of the Chicago-area HMOs (Chicago, Mile Square, and Med Care) during its 1988 study.⁵ Crescent Counties chose the average number of prenatal visits, the number of clinical management problems, and the number of potential adverse outcomes as indicators for evaluating the performance of an HMO in providing care to high-risk pregnant women.

Crescent Counties reported that Med Care had the poorest performance levels: the lowest average number of prenatal visits,⁶ the highest number of cases with clinical management problems identified by nurse reviewers (12 out of 13 compared with 0 out of 13 for Chicago HMO and 1 out of 13 for Mile Square), and the highest number of cases with

⁵Two cases were reviewed for Anchor and four cases for Illinois Masonic, but they were excluded from the discussion because of the size of the samples.

⁶Because of the way Crescent Counties computed the number of prenatal care visits, the data should be used only for comparison within the Chicago-area HMO program. It should not be compared with fee-for-service data or national averages because Crescent Counties (1) looked only at the 12 most recent visits for any purpose (this could result in some prenatal care visits being excluded); (2) did not determine whether the recipient enrolled in the HMO during the pregnancy (if she was already pregnant on enrollment, this would decrease the number of prenatal visits the HMO would be expected to provide); (3) did not determine whether the recipient disenrolled during the pregnancy (this would decrease the number of prenatal visits the HMO would be expected to provide); and (4) limited its review of prenatal care to visits between April 1, 1987, and April 1, 1988 (this would exclude some prenatal care visits for recipients whose pregnancies began before April 1, 1987, or ended after April 1, 1988, again reducing the number of visits an HMO could be expected to provide).

potential adverse outcomes identified by nurse reviewers (6 out of 9 compared with 2 out of 9 for Chicago HMO and 0 out of 9 for Mile Square).

In a February 2, 1989, response to the Crescent Counties report, Med Care questioned the validity of the statistics Crescent Counties cited. Med Care is in the process of looking at the incidence of high-risk pregnancies, it said, to discover causative factors surrounding potentially adverse outcomes, adding that it would

- develop educational programs focusing on preventive care and documentation of care provided,
- encourage participation in the Beautiful Babies program,⁷ and
- develop a Med Care prenatal care record.

Quality Assurance Staff Confirm Problems at Med Care

IDPA's Medical Audits and Quality Assurance section followed up on the 1988 Crescent Counties findings. In an April 5, 1989, letter to Med Care, IDPA stated that most of the medical records reviewed lacked documentation of adequate obstetrical care. Furthermore, IDPA found no evidence that prenatal high-risk assessments were being performed in many of the prenatal cases reviewed. In commenting on a draft of this report, Illinois said that after completion of the chart reviews at Med Care, IDPA began performing chart reviews for all remaining HMO sites.

Actions Needed to Ensure Informed Consent Requirements Met

Although Medicaid regulations require informed consent before hysterectomies or sterilizations are performed on Medicaid recipients, both HCFA and IDPA reviewers have identified several instances in which patients' medical records did not contain evidence of consent having been obtained. IDPA, however, did not document follow-up on these instances in order to determine whether (1) the patient had given informed consent, but the HMO had failed to document it in the medical record; (2) the procedure was appropriate, but the consent procedures were not followed; or (3) the procedures were inappropriate. In addition, IDPA has not adequately followed up to determine the extent of the problems identified.

⁷This program is sponsored by the University of Chicago hospitals and WBBM-TV to help the fight against infant mortality in Chicago. The program offers expectant and new parents discounts for food and clothes in exchange for the mother's keeping appointments with her health care provider.

Medicaid funds can be used to pay for sterilizations only if a person is at least 21 years old, is not mentally incompetent, has voluntarily given informed consent in writing on a HCFA-prescribed form, and a specified time has passed between the date of informed consent and the date of sterilization; Medicaid funds can be used to pay for hysterectomies only if (1) the procedure is not performed for the primary purpose of making the woman sterile and (2) the woman signs a written consent form stating that she was informed before the procedure that it would make her sterile. These requirements were established after examples of sterilization abuse under federal programs were widely publicized in 1973.

In August 1987, HCFA reported on its review of Chicago-area HMOs. Of the four HMOs that HCFA visited in which sterilizations or hysterectomies had been performed, documentation showed that the required written consent was not always available in three. At one HMO, HCFA looked at a sample of nine sterilizations and three hysterectomies and found the required consent forms in the medical record for only one of the people sterilized. At a second HMO, one sterilization, but no hysterectomies, had been done between July 1, 1986, and December 1, 1986; the consent form was on file. The other two HMOs that HCFA visited were unable to provide documentation that the required consent forms were on file; the HCFA report did not state how many sterilizations and hysterectomies were reviewed.

HCFA recommended that IDPA ensure that (1) federal requirements concerning sterilizations and hysterectomies are met and (2) HMOs be required to submit documentation that their providers and provider networks have been instructed to secure the required consent forms. HCFA did not, however, ask IDPA to follow up on (1) why the consent forms were missing from the medical records it reviewed or (2) how extensive the problem of missing consent forms was. In September 1987, IDPA instructed the HMOs to submit documentation that the HMO providers and provider networks had been instructed to complete the consent forms before performing sterilizations or hysterectomies. IDPA was able to provide evidence that only three HMOs had submitted plans for instructing providers on the requirements to complete the forms.

During the 1988 compliance audits, IDPA also tested compliance with the consent requirements. Reviewing random samples of about 1 to 7 percent of the medical records at each HMO, the IDPA auditors identified seven sterilizations (six at Chicago HMO and one at Mile Square) performed for which the medical records did not include the required consent forms. No indication was given of follow-up with either the

provider or the patients to determine why the consent form was missing; that is, was informed consent obtained but not documented or was the procedure performed without informed consent.

According to IDPA's supervisor, Medical Audits and Quality Assurance section, IDPA's audit staff are responsible for testing compliance with a requirement, but not for following up on the HMOs concerning corrective actions; that, he said, is his responsibility. The supervisor said he contacted the HMOs about the lack of consent forms, but could not provide documentation regarding the outcome of those conversations.

Conclusions

Reviews by IDPA's compliance auditors and quality assurance staff, as well as by Crescent Counties, have identified deficiencies in the documentation of services for Chicago-area HMO enrollees. None of the reviewers, however, has taken the next step—determining whether patients were underserved. Because of the incentives to reduce the number of services provided in order to increase profits, it is imperative that IDPA, to detect possible underservicing, assess both the quality and quantity of services provided.

High voluntary disenrollment from an HMO is another potential indication of underservicing or other quality-of-care problems. A patient satisfaction survey to determine the reasons for the disenrollments and the implications for care has not, however, been done. Nor has IDPA documented follow-up to determine why patient consent forms are not present in the medical records of some Medicaid recipients obtaining sterilizations or hysterectomies.

Recommendation to the Secretary of HHS

We recommend that the Secretary, through the HCFA Administrator, require IDPA to establish procedures to help ensure that adequate follow-up is conducted when potential quality-of-care problems are identified.

HHS Comments and Our Evaluation

HHS said that it will direct the HCFA regional office to work with IDPA to improve its oversight and follow-up efforts. HHS said that it recognizes the importance of quality assurance follow-up when potential problems are identified and requires a quality assurance "loop" in federally qualified HMOs.

HHS's action is an important first step in ensuring that Medicaid recipients receive quality care. HHS needs to identify the specific actions it

plans to take to improve oversight and follow-up and set timeframes for completing those actions.

Illinois Comments and Our Evaluation

Illinois said that it will assess its quality assurance activities and make necessary improvements to assure that HMO enrollees receive high-quality medical care. IDPA's quality assurance activities are, in the state's opinion, adequately documented. This information will, Illinois said, be given to HCFA for review.

We are encouraged by the state's plans to assess its quality assurance activities, but are disappointed that it identifies no specific plans to follow up on the problems identified in our report. Specifically, IDPA's comments are silent about plans to follow up on determining whether appropriate patient consent forms are obtained before sterilizations are performed. Given the number of instances cited in this report where we were unable to identify documentation of IDPA actions, we do not agree with the state's view that it is adequately documenting its quality assurance activities.

In summary, IDPA needs to focus on developing quality assurance activities that (1) more completely identify the magnitude of problems, (2) identify the underlying cause of the problems, and (3) ensure resolution of any problems affecting quality of care.

Chicago-Area HMOs in Program Since 1980

HMO	Participation dates
American	08/84-Present
Anchor	07/80-6/89
Chicago ^a	11/81-Present
Chicago Care	11/85-01/87
Compass	11/85-Present
Illinois Masonic	11/84-Present
Med Care	11/85-Present
Metro Care	08/84-03/87
Mile Square	01/85-06/88
University of Illinois	07/86-04/89

^aParticipated in the program between 1976 and November 1981 as the Roosevelt Health Maintenance Organization.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 18 1990

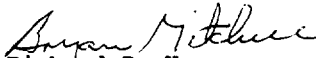
Ms. Janet L. Shikles
Director, Health Financing
and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicaid: Oversight of Health Maintenance Organizations in Chicago-Area." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,


FOR Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report, "Medicaid:
Oversight of Health Maintenance Organizations in Chicago-Area"

Overview

We are concerned about the overall impression conveyed by the report that health maintenance organizations (HMOs) in general "pose the danger of diminished quality of care." We would point out that HMOs can improve access to health care for Medicaid enrollees who may have limited access to providers in the fee-for-service setting. We are also concerned with GAO's general criticism of HMO provider capitation methods and several of the report's recommendations. Our more specific comments on the report's recommendations and discussion of capitation and risk arrangements, minimum enrollment standards and Medicaid HMO provider subcontractor requirements follow.

We do not agree with the GAO presumption that capitation and risk pools, in all likelihood, will lead to inappropriate reductions in medical services to Medicaid recipients. The Chicago-area Medicaid HMOs employ capitation and risk pool methods identical or similar to those used by commercial HMOs providing quality health care services to over 32 million enrollees, including employees of the Federal government and nearly 2 million Medicare beneficiaries. Although general concern has been expressed about HMO financial incentive arrangements in the past, no study has ever demonstrated that capitation risk arrangements reduce quality of care. In fact, in a recent HHS report to Congress on financial incentive plans in Medicare-contracting HMOs, it was reported that ". . . there is no evidence available to support the hypothesis that these plans result in unacceptable levels of care and poor quality. Similarly, there is no evidence to support the hypothesis that some financial incentives have more influence on behavior than others, and therefore, more potential influence on quality than others."

Capitation payments are intended to adequately compensate providers that appropriately manage an enrollee's total health care needs. Financial risk is an essential element in capitation arrangements. Financial incentive serves the purpose of preventing unnecessary or inappropriate utilization and encouraging the provision of care in the appropriate setting. We believe GAO's attempt to demonstrate that accepted industry-wide capitation payment standards lower

Page 2

quality of care is conjectural and inconclusive. GAO hypothesized that fewer services would be provided to Medicaid enrollees serviced by capitated providers, but did not conclude or prove that services were not provided as a result of the capitation and risk pool arrangements.

In its report, GAO does not approve of provider risk-sharing arrangements. We would point out that Federal law permits federally qualified HMOs and Medicare-contracting HMOs to arrange for physicians or institutions to assume all or part of the financial risk for providing health services. Further, the previously referenced HHS report on provider financial incentives was provided to assist Congress in its determination of risk arrangements that should not be permitted in Medicare. We would expect that any risk arrangement found to be not permissible for Medicare HMOs would similarly be prohibited for Medicaid HMOs. Unless Congress passes legislation, we believe it would be inappropriate to prohibit specific risk arrangements.

Further, in the report GAO discusses the application of minimum enrollment requirements to Medicaid contracting HMOs and to risk-based subcontractors. In Medicare, the minimum enrollment standard applies to the HMO (the contracting entity), not to subcontracting providers. GAO correctly describes the 5,000 member requirement for Medicare-contracting HMOs, but incorrectly asserts that this ensures an adequate base over which to spread risk, thereby lessening the likelihood that an individual physician's clinical decisions will be made for financial reasons. There is no correlation between the minimum enrollment of 5,000 members and risk arrangements with individual physicians. Therefore, it would be inappropriate to adopt the minimum enrollment requirement to remedy perceived problems with the HMOs' or subcontractors' risk-sharing arrangements.

GAO Recommendation

We recommend that the Secretary of HHS, through the Health Care Financing Administration (HCFA) Administrator, direct the Illinois Department of Public Aid (IDPA) to require HMOs entering into contracts with medical groups and Individual Practice Associations (IPAs) on a risk basis to require their subcontracting health plans to comply with basic criteria for risk-based contracting. Specifically, subcontracting health plans should be required in writing to (1) prove their financial solvency, (2) have a plan for handling insolvency, and (3) hold the number of Medicaid enrollees to less than 75 percent of their membership.

Page 3

Department Comment

GAO's recommendation is based on an incorrect interpretation of 42 CFR 436.6(a)(11)(b), which requires subcontractors to fulfill the requirements that are appropriate to services or activities delegated under the subcontract. However, regulations are silent regarding specific services or activities.

HCFA already has provided GAO with its interpretation of the regulation in a memorandum dated February 27, 1990. As stated in that memorandum, our position concerning which requirements apply to the HMO as opposed to the subcontractor is as follows:

Proof of Provision Against the Risk of Insolvency

If the HMO has satisfied this contract requirement with financial reserves and reinsurance provisions adequate to the State and the Secretary, or if the provider subcontractors agree in writing not to make Medicaid enrollees liable for the HMO's debt if it does become insolvent, the requirement for each provider subcontractor to provide proof of financial responsibility/insolvency is not appropriate.

75/25 Enrollment Composition

If the HMO has satisfied this contract requirement with its aggregate enrollment, the requirement for the provider subcontractor to maintain a 75/25 enrollment composition is not appropriate.

GAO Recommendation

We recommend that the Secretary of HHS, through the Administrator of HCFA, direct IDPA to:

- review the accuracy and completeness of medical care utilization data and assess financial penalties for inaccurate or incomplete data; and
- establish criteria for expected utilization and develop screens to detect possible underservicing by physicians, medical groups subcontracting with HMOs, or HMOs.

Page 4

Department Comment

HHS lacks statutory authority to require States to specifically assess financial penalties for inaccurate and incomplete data. We have statutory authority to impose civil monetary penalties upon Medicaid HMOs, but this authority does not authorize penalties in this situation. It is also uncertain as to whether we have authority to direct the IDPA to establish criteria for expected utilization and develop screens to detect possible underservicing. Given the absence of direct authority, we have previously recommended (as was pointed out in the GAO report) that the HCFA Regional Office work with the State to correct quality assurance program inadequacies identified in the quality assurance evaluation and the PRO reviews commissioned by IDPA. We will further recommend that the HCFA regional office work with the State to improve the State's general oversight and follow-up efforts.

GAO Recommendation

We also recommend that the Secretary (1) develop standards for utilization reporting systems for prepaid health systems and (2) require States to include such reporting systems in their MMIS. Finally, we recommend that the Secretary develop guidelines for reviews by peer review organizations of HMOs and other prepaid health programs that require an assessment of potential underservicing of Federal beneficiaries.

We note that current utilization review systems, including Medicaid management information system (MMIS) and peer review activities, are oriented toward controlling the provision of unnecessary and inappropriate medical services. We recognize the importance of quality assurance follow-up when potential problems are identified. In fact, we require a quality assurance "loop" in federally qualified HMOs. We believe that it would be worthwhile to examine how underutilization may be detected, possibly leading to the development of quality assurance and utilization review specifically for Medicaid prepaid health plans. This could include protocols to monitor underutilization of medical services. However, we do not believe that the MMIS is appropriate for managing Medicaid's involvement with prepaid plans. Rather, smaller, more flexible systems which are specifically designed for this purpose should perform this important function and summary statistics from these subsystems could then be integrated into the MMIS.

Page 5

GAO Recommendation

We recommend that the Secretary of HHS, through the HCFA Administrator, require IDPA to establish procedures to help ensure that adequate follow-up is conducted when potential quality-of-care problems are identified.

Department Comment

As previously discussed, we will direct the HCFA regional office to work with IDPA to improve its oversight and follow-up efforts.

Comments From the State of Illinois



STATE OF ILLINOIS
OFFICE OF THE GOVERNOR
SPRINGFIELD 62706

JAMES R. THOMPSON
GOVERNOR

April 27, 1990

Ms. Janet L. Shikles, Director
United States General Accounting Office
Health Financing and Public Health Issues
Human Resources Division
Washington, D.C. 20548

RE: GAO/HRD-90-81

Dear Ms. Shikles:

Thank you for the opportunity to respond to the draft report entitled Medicaid: Oversight of Health Maintenance Organizations in Chicago-Area.

If DHHS/HCFA determines that corrective action is appropriate or changes to Federal Regulations are required, the State of Illinois will cooperate with those initiatives. The State of Illinois is dedicated to providing quality health care in the most cost effective manner.

If you have any questions, please contact Mrs. Kathleen Kustra, Director, Illinois Department of Public Aid at 217/782-6716.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "James R. Thompson".

James R. Thompson
GOVERNOR

JRT:KBK:JRD:jec

Attachment

cc: Kathleen Kustra

Illinois Comments and GAO Evaluation

The Illinois comments on the following pages have been extracted verbatim, in sequence, from its April 27, 1990, letter. Each section of the Illinois comments is followed by our evaluation. Page references in the Illinois comments have been changed to correspond with the final report.

Illinois Comment 1

Executive Summary Incentive plans weaken the quality of care Pages 2 & 3 — A number of studies have shown that while HMOs have lower hospitalization rates, the quality of care delivered is as good or better than Fee-For-Service.* There is no consensus among the medical profession that reduced utilization equals poor quality care. Over utilization of services is generally acknowledged to be driven by financial considerations, and care in excess of patient needs is an established indication of poor quality of care.

GAO Evaluation

As stated on page 2, one of the advantages of HMOs is that they have a financial incentive to assure that only necessary care is provided. We agree that the amount of services provided to patients may be driven by financial considerations and that care in excess of patient needs can be an indicator of poor quality care. Withholding or delaying needed care is also an indication of poor quality care. As discussed on page 2, the Congress has required that HMOs have quality assurance programs designed to prevent HMOs from responding inappropriately to the financial incentives to control utilization.

The financial incentives to control utilization vary by type of HMO. Generally, the closer financial incentives are to individual treatment decisions and the more risk shifted to the physician, the higher the potential for adverse effects on quality of care. Both Med Care and Chicago HMO use financial incentives that closely tie treatment decisions to financial reward. This, in our opinion, heightens the need for an effective quality assurance program.

We are not suggesting that all financial incentives to control utilization are wrong or that they necessarily weaken the quality of care provided.

*See: Group Health Assn. of America; HMO Industry Profile, 1989, Vol. II; Luft, Harold S., HMOs: Dimensions of Performance. Cunningham, Frances C.; "How Does Quality of Health Care in HMOs Compare to that in Other Settings?", Group Health Journal 1., (Winter 1980). Manning, Wm. M.; "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services", New England Journal of Medicine. #310 (June 1984). Ware, John E.; "Comparison of Health Outcomes at an HMO with Those of Fee-For-Service Care", Lancet (May 1986).

Rather, we are suggesting that (1) some financial incentives create greater potential for adverse effects on quality than others and (2) a determination needs to be made as to whether quality assurance programs can adequately protect federal beneficiaries.

Finally, we do not question the ability of HMOs, in general, to provide quality care or reduce unnecessary hospitalizations. We do not believe, however, that studies of the quality of care provided by other HMOs have any pertinence to an assessment of Chicago-area HMOs serving Medicaid recipients.

Illinois Comment 2

Chapter 2 Physician Incentive Plans

Page 16—The GAO report states that Chicago HMO and Med Care “place individual physicians at high risk and closely relate clinical decisions to financial gain.”

This implies that physicians are penalized or rewarded on a case-by-case basis for each medical decision. Cost control incentives are, in reality, shared in the aggregate. If utilization of a service component rises alarmingly high, it is reviewed for inappropriate usage and for ways to contain it. Appropriate changes are then implemented.

GAO Evaluation

As discussed above and on page 17, the closer financial incentives are to individual treatment decisions and the more risk the physician has, the higher the potential for adverse effects on quality of care. Cost control incentives are not shared “in the aggregate” at Med Care and Chicago HMO. Both are network-type HMOs (1) shifting substantial risk to subcontractors, which function essentially as mini-HMOs, and (2) distributing incentives based on the performance of these subcontractors, frequently composed of a handful of primary care physicians. The subcontractors may, in turn, shift substantial risk to individual physicians through capitation. The low number of enrollees in the provider groups also tends to more closely tie financial gain or loss to individual treatment decisions. As discussed on page 22, one Med Care IPA had only three enrollees, all Medicaid recipients.

Finally, we agree with Illinois’s statement that if utilization rises alarmingly high, it should be reviewed for inappropriate use and appropriate changes implemented. We reviewed state efforts, including those of Illinois, to identify and correct overutilization of services, under fee-for-

service, in an earlier report.¹ We believe Illinois should also identify and review cases in which utilization is alarmingly low and take appropriate action.

Illinois Comment 3

The GAO report states that federal regulations require individual clinics who contract with HMOs, to prove their solvency, develop plans for insolvency and enroll specified percentages of private members. The federal regulation (42 CFR 434.6-b) requires subcontracts to fulfill the requirements that are appropriate to the service or activity delegated under the subcontract. The only services delegated under the subcontract are the provision of medical services. The financial and patient mix requirements of federal regulations are the responsibilities of the HMOs, not the subcontractors. To require every clinic in Chicago willing to accept Medicaid clients to maintain a 25 percent commercial patient mix would devastate access to care in impoverished areas. The federal regulation does not apply to individual clinics (subcontractors), nor are we aware of a single state in the nation which applies these standards to individual clinics.

GAO Evaluation

This comment and our evaluation were incorporated in the body of the report on page 32.

Illinois Comment 4

Pages 16, 23 and 24 — The GAO report poses the argument that the high turnover of enrollees “could” increase the incentives to delay or deny medical care because it would be financially advantageous. No evidence that this occurs is offered in the GAO report, nor does it explain how the physicians will know in advance which patients will disenroll and which will remain. In short, there is nothing to support the opinion that such a disincentive exists.

GAO Evaluation

We are not suggesting that physicians know in advance which patients will disenroll and which will remain with the HMO. If, however, enrollees usually disenroll within 5-1/2 to 6 months, as the president of Med Care stated, the adverse effects of delaying treatment, particularly preventive health services, are unlikely to occur before the patient disenrolls. As discussed in chapter 4, there is little evidence that adequate preventive care services are being provided. While many factors contribute to

¹Medicaid: Improvements Needed in Programs to Prevent Abuse GAO/HRD-87-75; Sept. 1, 1987.

this problem, we believe the limited risk of adverse effects of delaying care occurring before a Medicaid recipient disenrolls contributes to the problem.

Illinois Comment 5

Recommendation Page 24

The Department believes that it is currently in compliance with the Federal Regulations requiring subcontractors to comply with the regulations appropriate to their service or activity. Again, we believe that to require subcontractors to comply with the same federal regulations would devastate access to care in impoverished areas.

GAO Evaluation

This comment and our evaluation have been incorporated in the body of the report at page 32.

Illinois Comment 6

Chapter 3 Identification of Quality of Care Issues

Pages 34-37 — We disagree with the GAO report that the HMOs have made “limited progress” in developing Quality Assurance Programs. Our compliance audits have documented the improvements in HMO Quality Assurance Programs. The Department has worked closely with each HMO to further enhance these programs. A Department of Health and Human Services letter dated April 11, 1988 to Chicago HMO summarizes the result of an HHS evaluation that found the accessibility to care, the care provided, and the Quality Assurance program of that HMO, met the federal statutory and regulatory requirements. Chicago HMO represents the vast majority of HMO enrollees.

GAO Evaluation

As stated on page 36, the 1988 audits for contract compliance did not test compliance with the Health Shared recommendations; the 1989 audits had not been completed as of May 15, 1990. With the exception of correspondence between IDPA and Chicago HMO, we found little evidence in IDPA records to support the state's contention that it has worked closely with each HMO to enhance its quality assurance programs. Changes have been made in the final report to reflect IDPA's efforts to work with Chicago HMO.

Illinois Comment 7

The GAO report states that HMO Quality Assurance programs only look at overuse of hospital services rather than broad quality of care issues. The Department receives Quality Assurance minutes from each HMO which clearly show that the programs focus on quality of care issues. Additionally, Department staff attend HMO Quality Assurance meetings to monitor Quality Assurance activities. We maintain that the Department's actions have resulted in greatly improved Quality Assurance programs which meet federal standards.

GAO Evaluation

On page 34, we said, the HMOs' quality assurance programs look primarily at overuse of hospital services; this statement was based on the (1) findings of Health Shared and HCFA and (2) absence of documentation in IDPA records that adequate improvements had been made in the programs (other than by Chicago HMO). Further, some of the quality assurance minutes, such as those prepared by Chicago HMO, have a clear focus on quality of care; others, such as those of Illinois Masonic Community Health Plan and American HMO, continue to primarily deal with quality issues as identified only by hospital utilization reviews.

In an October 10, 1989, memorandum to the compliance auditors, the IDPA quality assurance staff said that at American HMO, "There is no evidence that any type of active quality assurance, utilization review or peer review is being performed at the clinical level." A similar statement was included in a September 26, 1989, IDPA memorandum concerning Compass HMO. The memorandum went on to say that "There were only three individual practitioners that were involved in any type of peer review activity. There [sic] involvement is limited to reading the newsletters from the IPA president or Corporate newsletter [sic]."

A September 26, 1989, summary of the IDPA site visit to Illinois Masonic concluded that "There was evidence of active participation and on-going involvement in quality assurance and peer review as is evidenced by the monthly meetings." But our review of the minutes of two such meetings found them to be hospital utilization review meetings. IDPA provided the minutes to us as examples of quality assurance meetings. The minutes from one meeting state that a guest observer from IDPA "was very favorably impressed by the process."

There was no indication in the site visit report, prepared by the quality assurance staff, that the determination that the HMO had an adequate quality assurance program was based on anything other than hospital utilization reviews. In summary, while progress has been made since the

quality assurance staff was hired in 1988, there is little indication that many HMOs have developed quality assurance programs that meet federal standards.

Illinois Comment 8

Page 36 — The GAO report incorrectly claims that Med Care did not submit a corrected Quality Assurance plan in the fall of 1987 as required. The Department received the corrected plan in February 1987 and a revised plan in October 1987.

The Department required corrective action plans from all HMOs beginning in FY '88. In addition, the Department staffed an entire unit to monitor corrective actions, and initiated on-site verification of the quality of care.

GAO Evaluation

Although Med Care submitted a revised quality assurance plan in February 1987, the plan did not address recommendations made in the Health Shared report, which was not issued until April 1987. Further, although Med Care revised the plan again in October 1987, IDPA did not provide documentation that the revisions specifically addressed the Health Shared recommendations; IDPA did not produce correspondence from Med Care stating how the changes addressed the recommendations nor a record of its own review of the plan to determine compliance. IDPA was able to identify review comments for an October 1988 revision of Med Care's quality assurance plans. The comments did not, however, discuss the Health Shared recommendations. Page 36 has been revised to clarify IDPA's activity.

The requirement to develop corrective action plans, the establishment of the quality assurance group to monitor corrective actions, and the group's on-site verification of quality of care are discussed on pages 36, 51, and 54. It should be noted, however, that as of May 1990, the quality assurance group had not reported the results of its assessment of compliance with the Health Shared recommendations relating to quality assurance plans.

Illinois Comments 9

Pages 34 and 37-39 — The GAO report states that one reason why they feel adequate utilization is not gathered by the Department is that clinic chart documentation does not always reflect the services rendered. However, the utilization data gathered by the Department is not derived from medical charts, it is submitted by the HMOs from clinic encounter

reports. The Department has standards for reporting which are included as part of the contract with the HMO.

GAO Evaluation

As discussed on pages 37 to 39, both Crescent Counties and IDPA identified serious deficiencies in the maintenance of Medicaid recipients' medical records. Crescent Counties found that the HMOs generally lacked effective systems to generate medical care utilization data. Although utilization data are submitted on "clinic encounter reports," the data on such reports should be derived from the medical records. As discussed on page 40, to determine the completeness of the data submitted, IDPA has not reported on its efforts to trace the data on the medical encounter reports back to the medical records. The wording on page 40 has been clarified.

Illinois Comment 10

The GAO report did not include that the rejected tapes are corrected by the HMO and resubmitted to the Department. The Department does receive accepted utilization data from the HMOs. FY '89 data is on computer tapes and the tapes are available for review. The GAO report is incorrect in stating on page 4 that the Department did not require data submittal until 1986. The Department has required hard copy data since inception of the HMO program.

GAO Evaluation

The report has been revised to (1) show that rejected tapes are corrected by the HMO and resubmitted to IDPA (p. 40), (2) clarify that detailed utilization data were not required before fiscal year 1986 (pages 4 and 39), and (3) state that fiscal year 1989 utilization data have been accepted from all Chicago-area HMOs (p. 40).

Illinois Comment 11

Page 40 — The current compliance audits of HMO performance over the last fiscal year are tracing reported utilization data back to the clients in order to determine the accuracy of the data.

GAO Evaluation

Page 40 discussed IDPA's plans to trace a sample of reported services back to the medical records during the 1989 audits for contract compliance. The comments incorrectly state that the data are being traced backed to Medicaid recipients. As of May 10, 1990, the reports on the 1989 compliance audits had not been completed. According to the manager, Prepaid Health section, about 60 percent of the records checked at

Illinois Masonic had problems. Similar problems, he said, exist at the other HMOs, except Compass.

Illinois Comment 12

Page 40 — The GAO report states that the Department has no plans to “examine a sample of medical records to determine completeness”. This is a requirement of the Crescent Counties evaluation and is a part of the ongoing Quality Assurance medical record reviews.

GAO Evaluation

Crescent Counties’ evaluation and the quality assurance groups’ medical records reviews assess the completeness of the medical records, not the completeness of utilization reporting. Neither group is testing the completeness of the tapes by tracing all services identified in the medical record to the utilization tapes. The wording on page 40 has been clarified.

Illinois Comment 13

Pages 42-43 — The GAO report claims that despite indications that “unexpectedly” large numbers of HMO enrollees were receiving no services from HMO, IDPA has not followed up to determine if services were not provided or just not documented. The GAO report conclusion is based on the Professional Review Organization (PRO)/Crescent Counties review in FY '87. Since the Crescent Counties review had never analyzed HMO ambulatory care systems, they assumed that 90 percent of Medicaid enrollees received services in that year. The GAO report did note that the PRO found only 70 percent of the sampled population received services. The GAO did not subsequently try to determine if the remaining 30 percent were denied needed care, did not need care or were provided undocumented care. However, on page 43 the GAO report conceded that under federal regulations “IDPA’s interpretation appears reasonable,” but suggests that HCFA establish a new interpretation that would require PROs to examine the possibility of underserving.

GAO Evaluation

Our conclusion that IDPA should follow up to determine if services were not provided or just not documented was not, as Illinois suggests, based on the 1987 Crescent Counties review. As discussed on page 42, IDPA’s 1987 audits for contract compliance found that 57 percent of enrollees sampled at five Chicago-area HMOs had no record of having received services from their HMOs. We believe it is IDPA’s responsibility, not ours, to follow up to determine why such a high percentage of Medicaid recipients appear to receive no services from their HMOs. IDPA could do this

either through its own quality assurance staff or, as we suggested, through its contract with Crescent Counties. As stated on page 43, failure to provide needed medical services may constitute poor quality care. We therefore continue to believe that peer review of HMOs should include an assessment of potential underservicing.

Illinois Comment 14

The PRO review examines both clinical management and adverse outcomes through examination of the services that are documented. If underservicing arose through breakdowns or deficiencies at the clinic level or if underservicing led to deterioration of health, they would be identified by the PRO. The Crescent Counties reviews indicated that sufficient information was found in many of the deficient charts to indicate that "appropriate care was given, despite documentation problems." The FY '88 PRO report also addresses improvements in most HMO's appropriateness of care evaluations from FY '87.

GAO Evaluation

As discussed on page 38, Crescent Counties expressed concern about the impact the lack of documentation could have on the quality of care provided by the HMOs. While Crescent Counties found other documentation to support the appropriateness of the care provided for many visits reviewed at some HMOs, it was unable to determine the appropriateness of much of the care provided by Compass and Med Care. For example, documentation problems were so severe at Compass that the physicians were unable to determine the appropriateness of the care provided in over 70 percent of the visits reviewed. Similarly, the physician reviewers were unable to find documentation to demonstrate the appropriateness of care given during 34 percent of the visits reviewed at Med Care.

In addition, Crescent Counties focused on the clinical management of individual episodes of care, not on the appropriateness of the overall pattern of care provided. As discussed on page 41, to assess the appropriateness of the types and numbers of services provided, states generally compare the services provided to some criteria defining expected utilization. For example, expectations might be set for

- the percentage of enrollees obtaining services over a certain period of time,
- the frequency of certain procedures,
- the number of referrals to specialists, or
- services per enrollee.

IDPA has not, however, set such expectations (see p. 41).

Even without expectations, IDPA could identify indications of under-servicing by comparing reported utilization between HMOs. For example, as shown in table 3.1, Compass reported providing significantly fewer services per enrollee than the other six HMOs. IDPA has not, however, followed up to determine why Compass reported fewer.

Illinois Comment 15

The Department began targeting chart reviews for each site identified as notably deficient in the FY '88 PRO Crescent Counties report. After completion of these chart reviews, the Department began performing chart reviews for all the remaining HMO sites. These reviews involved on-site inspections to determine the cause and extent of any clinical management, documentation or quality assurance coordination problems.

GAO Evaluation

Page 51 has been revised to indicate that the quality assurance group has also begun doing chart reviews for other HMO sites.

Illinois Comment 16

Recommendation Page 43

The Department believes that (1) utilization data reported by each HMO is accurate. We will review this issue with HCFA. (2) The Department does have unofficial criteria for expected utilization. The criteria will be formalized and documented.

GAO Evaluation

This comment and our evaluation have been incorporated in the body of the report on page 45.

Illinois Comment 17

Chapter 4 — Department Follow-Up on Quality-of-Care

Pages 47-48 — The GAO report claims that the Department was slow to determine why some clients voluntarily disenroll, whether “limited” preventive health services is due to documentation problems or under servicing, whether prenatal care is provided, or why some consent forms were not filed in HMO charts.

The Department has gathered disenrollment reasons for each disenrollee since 1984 which is available for review. In addition the Crescent Counties FY '88 report found that the volume of preventive services was about the same as episodic care and that 'well baby' care is being delivered during episodic visits. The Department's efforts to determine if preventive child care visits were under reported or not, are available for review.

GAO Evaluation

The reasons for voluntary disenrollments have not been adequately determined. One 1987 IDPA study states that enrollees voluntarily disenroll primarily due to dissatisfaction with services provided by HMOs. A second draft IDPA study indicates that enrollees voluntarily disenroll for a variety of reasons, but concluded that detailed information was still needed to study the specific reasons for voluntary disenrollments. Neither study included a patient satisfaction survey such as the one IDPA previously indicated it planned to conduct.

The Crescent Counties 1988 report indicates that overall preventive visits were about the same as episodic visits for children under 1 year of age. However, the report also states that one could logically expect a higher rate of preventive versus episodic visits for the population studied, but the Crescent Counties' review did not support this expectation. Only four HMOs had more preventive than episodic visits and the differences were not substantial, according to Crescent Counties. As one possible explanation of the low number of preventive visits, "It is probable," states the report, that well-baby care is being delivered during episodic visits. Med Care had a higher rate of problems in growth and development charts, patient education, and follow-up instruction; Crescent Counties states that while the information may have been provided and simply not documented, it is impossible to know from the available data.

Illinois Comment 18

The same report found that of the three HMOs with significant numbers of perinatal (occurring near the time of birth) cases, two had "above average" numbers of prenatal visits. The Department's own Quality Assurance staff also implemented prenatal care monitoring of HMOs early in 1989.

GAO Evaluation

As pointed out in a footnote on page 53, because of the way Crescent Counties computed the number of prenatal care visits, the data should

be used only for comparisons within the Chicago-area HMO program. Comparisons with other health care delivery systems or national averages are not appropriate. We have revised page 54 of the final report to reflect the prenatal-care monitoring begun by IDPA's quality assurance group in early 1989.

Illinois Comment 19

Page 48 — The GAO report states that a Department study shows voluntary disenrollment tends to be because of dissatisfaction with the services provided. Actually, the study states that dissatisfaction with the plan, not the services provided, is the major reason given. The study also states that 32 percent of those questioned have no specific reason for disenrolling; and that disenrollment declines drastically the longer the clients are enrolled.

GAO Evaluation

The published 1987 study we cited—Disenrolling From Health Maintenance Organizations Among Illinois Medicaid Beneficiaries—states that “voluntary disenrollees tend to disenroll due to dissatisfaction of services [emphasis added]....” The study does not mention dissatisfaction with the plan.

Illinois Comment 20

Page 49 — The GAO report correctly states that our compliance auditors found little chart evidence that preventive services were provided, but fails to mention that Crescent Counties' physician consultants were able to determine that these services were provided, with the exception of Med Care, and that preventive services equaled, and in some categories exceeded, episodic care.

GAO Evaluation

As discussed above (p. 76), Crescent Counties expected to find a higher rate of preventive than episodic visits, but generally found evidence of fewer preventive visits than expected. Crescent Counties 1987 and 1988 reviews are discussed on page 51. As discussed in the footnote, Crescent Counties found documentation problems at all HMOs, except Mile Square, in 1987, but a relatively low rate of problems at all but Med Care in 1988.

Illinois Comment 21

Pages 48-51 — Contrary to the GAO reports' conclusions, the Department followed up with each HMO to determine why more Healthy Kids services were not reported in submitted data, and found that the major

problem was in the Department's analysis of the utilization data. Chart reviews were conducted by the Department's Quality Assurance staff, and our FY '89 analysis of immunizations shows over 13,000 immunizations by HMOs that year. For FY '90 to date, over 15,000 immunizations were reported to the Department. We believe that this supports our contention the previous levels appeared low due to under-reporting and that reporting is improving. In addition, the Crescent Counties' FY '88 evaluation of care provided to children under seven years of age stated, "there is also a relatively low rate of problems identified."

GAO Evaluation

We agree with the state's conclusions that its analysis of utilization data tapes to identify Healthy Kids services was flawed. The follow-up IDPA cites in its comments, however, was to determine why few Healthy Kids services were included in the HMOs' utilization tapes. We do not contest IDPA's statement that reporting of Healthy Kids services, under its utilization data system, is improving.

We do not agree, however, that the low levels of Healthy Kids services identified, through the contract compliance audits and Crescent Counties reviews, are explained by problems in utilization reporting; the low levels were based on reviews of documentation present in medical records. The 1987 and 1988 Crescent Counties findings with regard to documentation problems are discussed on page 51.

Page 51 has been revised to show that chart reviews were conducted by IDPA's quality assurance group after we brought the issue to the attention of the supervisor of Medical Audits and Quality Assurance in May 1989.

Illinois Comment 22

Page 51 — The GAO report states that the Department's chart reviews did not determine whether services were not provided or not documented. In the absence of chart documentation, a chart review cannot make such a determination. Where documentation was available, the PRO evaluations were able to determine that the problem is one of adequate charting, and that there is no evidence that needed services are not provided. Current utilization data suggests that services are performed. The Quality Assurance staff has proceeded to assist HMOs in improving their documentation at the clinic, as well as at the corporate level. The Quality Assurance staff performed these functions in the area of prenatal care instead of the compliance auditors, due to their medical expertise.

GAO Evaluation

We are not suggesting that chart reviews can be used to determine whether services were not provided or not documented. An effective oversight system should, in our opinion, provide for going beyond the medical charts in order to determine whether services were provided as needed. Whenever appropriate, the reviewer should discuss individual cases with the providers and the patients to find out whether additional care was provided. The only other acceptable approach, in our opinion, is to assume that care was not provided if it was not documented in the medical charts.

We disagree with Illinois's contention that when documentation was present, Crescent Counties was able to determine that there was no evidence that needed services were not provided. As discussed on page 38, Crescent Counties expressed concern in both 1987 and 1988 about the impact the lack of documentation could have on the quality of care provided by the HMOs. For example, Crescent Counties was unable to determine the appropriateness of the care provided by Compass physicians in over 70 percent of the cases reviewed. Finally, we are not questioning whether services are performed. Our report recognizes throughout that the HMOs are providing some services and submitting some utilization data. We question, however, whether appropriate numbers of services are being provided and reported.

Illinois Comment 23

The audit criticizes Crescent Counties for assessing the adequacy of perinatal care of only three HMOs, without noting that the PRO explained that only those three HMOs have enough perinatal cases to draw any conclusions. The audit incorrectly states that Quality Assurance staff only followed up with chart reviews at the Med Care sites identified as deficient by Crescent Counties. The Department staff started with the Compass and Med Care sites identified as deficient by the PRO report, and then performed systematic and ongoing chart reviews and site inspections of every HMO site. Finally, the Department commissioned Crescent Counties to focus on HMO prenatal care in their FY '89 review.

GAO Evaluation

Our report states in a footnote (p. 53) that Crescent Counties excluded two HMOs—Anchor and Illinois Masonic—because of the low number of prenatal cases reviewed. Prenatal cases were reviewed by Crescent Counties only if they were identified in the random sample of recipient records chosen for review. Because of the allegations contained in the Sun Times articles, we believe a more focused review of prenatal care was warranted. Page 54 of the final report has been revised to indicate

that the quality assurance group conducted site visits at all other HMOs after completing visits to Med Care.

Illinois Comment 24

Recommendations Page 56

The GAO report recommends that HCFA require IDPA to establish procedures to ensure adequate follow-up on quality-of-care issues. We believe we are adequately documenting the Department's Quality Assurance activities and we will provide this information to HCFA for review. The Department will assess its quality assurance activities and make necessary improvements to assure that HMO clients receive high quality medical care.

GAO Evaluation

This comment and our evaluation have been incorporated in the body of the report on page 57.

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