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**Testimony**

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**MEDICARE**

**Increased Federal Oversight of  
HMOs Could Improve  
Quality of and Access to Care**

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Mr. Chairman and Members of the Committee:

We are pleased to be here to assist in the Committee's continuing efforts to ensure that Medicare beneficiaries have access to quality care and fair treatment in their health maintenance organizations, or HMOs. Today we are issuing a report requested by this Committee entitled Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155). The report discusses problems that the Health Care Financing Administration (HCFA) has had monitoring HMOs it contracts with to provide services to Medicare beneficiaries, and ensuring that they comply with Medicare's performance standards.<sup>1</sup> Many of these problems are long-standing and have been the subject of continuing congressional oversight and GAO reports. (See app. I for a list of related GAO products.)

Today I would like to focus my remarks on HCFA's (1) monitoring of Medicare contract HMOs' compliance with quality-related standards, (2) enforcement actions when an HMO has failed to comply with these standards, and (3) implementation of beneficiaries' right to appeal HMO denials of care. In addition, I would like to highlight emerging private sector methods used to ensure quality and value in HMOs. To develop this information, we interviewed HCFA officials, reviewed internal HCFA policies and reports, analyzed three cases in which HCFA was taking special enforcement actions against individual HMOs, and documented HMO accreditation and performance measurement practices used in the private sector.

In brief, we found weaknesses in HCFA's quality assurance monitoring, enforcement measures, and appeal processes. Specifically, we found that, although HCFA routinely reviews HMO operations for quality, these reviews are generally perfunctory and do not assess the financial risks HMOs transfer to providers. Moreover, HCFA collects virtually no data on services received through HMOs to enable HCFA to identify providers who may be underserving beneficiaries.

In addition, HCFA's HMO oversight has two other significant limitations: enforcement actions are weak, and the beneficiary appeal process is slow. In enforcing Medicare standards, HCFA has been reluctant to take strong action against HMOs that fail to comply. For the cases we reviewed, deficiencies persisted for years. In its appeal process, HCFA allows 6 months or more for

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<sup>1</sup>When we discuss HCFA's monitoring of HMOs in this testimony, we are referring to both HMOs and Competitive Medical Plans holding Medicare risk contracts for prepaid care. Competitive Medical Plans are subject to regulatory requirements similar to those for HMOs, but they have more flexibility in how they set premiums and services for commercial members. Currently, there are about 164 Medicare risk contract HMOs.

resolution, which can create uncertainty or high out-of-pocket costs for beneficiaries.

HCFA's current regulatory approach to ensuring good HMO performance appears to us to lag behind the private sector. The private sector has developed strategies for ensuring quality and value in HMO selection, including collecting more information on HMO performance, providing the information to consumers, and demanding accreditation reviews. These strategies provide models for improving federal oversight of Medicare HMOs.

## BACKGROUND

Although less than 10 percent of Medicare beneficiaries are now in HMOs, recent growth in enrollment and in HMO applications for Medicare contracts has accelerated. In addition, the Congress is considering ways to attract more beneficiaries to HMOs and other forms of managed care in the hope of containing cost growth while preserving quality and access to care.

To encourage commercial and Medicare use of HMOs, in the early 1970s the Congress authorized standards and oversight to ensure reasonable care and service to beneficiaries. As the government gained experience with HMOs, federal standards were strengthened. HCFA is responsible for setting standards for Medicare HMOs' financing, quality of care, and fair treatment of beneficiaries. HCFA is also responsible for enforcing compliance with these standards.

First, HMOs must meet financial solvency requirements, have minimum enrollments necessary to assume the financial risks, and provide adequate administration and management. Second, the plans must have quality assurance systems to detect and correct patterns of underservice and poor-quality care, provide reasonable access to specialists and services, and not transfer excessive financial risk to providers. Third, HMOs must use fair marketing practices that do not mislead or confuse enrollees, provide necessary and covered services, and follow equitable grievance and appeal procedures.

HCFA monitors for continued compliance with requirements by reviewing an HMO's operations every 2 years and through collection and review of performance indicators such as complaints and disenrollments. In addition, HCFA contracts with state-based medical peer review organizations (PRO), which employ local doctors and nurses to assess the quality of care provided in HMOs. The PROs review both care provided to a sample of beneficiaries and all quality of care complaints. Currently, HCFA is revising the PROs' mission to emphasize assessment of patterns of medical practices for treating or preventing specific conditions.

To enforce HMO compliance with federal standards, HCFA is authorized to impose a number of sanctions, including stopping

enrollment, assessing monetary penalties, and terminating a contract. HCFA also has administrative ways to encourage compliance, such as withholding an HMO's request to expand its service area.

#### PERFUNCTORY MONITORING MAY NOT DETECT QUALITY ASSURANCE DEFICIENCIES

We found that HCFA's monitoring process is insufficient to verify HMO compliance with critical quality assurance standards. Every 2 years, HCFA reviews Medicare HMO systems for monitoring and controlling quality of care. However, these on-site reviews are too limited and are conducted by staff who lack the skills required to verify that the HMO systems actually meet federal standards. In addition, HCFA has not required the HMOs to provide information on their beneficiaries' encounters with doctors and therefore lacks the data to assess patterns of utilization of care. HCFA also has not assessed the financial risks that HMOs place on their providers.

#### Reviews Lack Depth and Expertise

HCFA's routine on-site reviews check only that an HMO has procedures and staff capable of quality assurance and utilization management--they do not check for effective operation of these processes. In addition, we found that the reviews focus largely on Medicare requirements for administration, management, and beneficiary services. About one-third of each review does examine quality assurance issues, but HCFA's review teams generally lack the specialized training and experience that would enable them to adequately assess the HMO's quality assurance and utilization management. Moreover, HCFA review teams do not draw on the specialized training and experience of PRO staff that could help to verify that HMOs' quality assurance programs work.

In some cases, these routine reviews have failed to detect deficiencies. In the South Florida case we reviewed, the PRO found significant quality of care problems at the same time that routine HCFA on-site visits identified no problems in HMO quality assurance practices. PRO findings included cases of incorrect diagnoses, inappropriate treatment plans, and delayed treatment. Only after years of negative PRO findings did HCFA comprehensively investigate the quality assurance practices of the South Florida and other HMOs.

#### Little Information on Patient-Provider Encounters

HCFA's lack of patient-provider encounter data, which are vital to assessing beneficiary use of services, also limits the effectiveness of HCFA's monitoring. Federal standards require that HMOs have information and management systems to collect and monitor

these data. Yet HMOs often lack encounter data, and HCFA has not required that such data be standardized or submitted to it and to the PROs. HCFA has been reluctant to impose uniform data requirements on HMOs.

#### Little Attention Paid to Risk-Sharing Arrangements

HCFA's HMO quality assurance monitoring also does not assess whether financial risks transferred to HMO providers create significant incentives to underserve. The Congress gave the Department of Health and Human Services (HHS) authority, effective April 1991, to limit arrangements that it judged too risky. However, HCFA officials noted that defining acceptable risks has proven complex, and as of July 1995, HHS had not issued implementing regulations and standards. This leaves reviewers with no standard by which to assess a deficiency.

One HMO whose financial-risk arrangements with providers had been of concern to HCFA reviewers for several years also had a high number of quality of care problems. The HMO uses about 23 percent of its Medicare payment for ambulatory care to administer the program; the remaining 77 percent of the payment is used to make fixed, per-enrollee payments to providers. The providers--often individual physicians or small physician groups--are responsible for providing HMO enrollees all needed ambulatory services from these payments. Several providers have lost money on care they provided to HMO patients, which could give providers incentives to withhold services.

#### HCFA RELUCTANT TO USE ENFORCEMENT AUTHORITY

In the three enforcement cases we reviewed and in our past reviews, we found that HCFA has not used its sanction authority to take prompt and strong enforcement actions to correct problems such as abusive sales practices, slow servicing of claims, delays in deciding appeals, and quality assurance deficiencies.

HCFA officials have stated that pursuing sanctions against noncompliant HMOs can be cumbersome and require many staff. Instead, HCFA seeks to document the causes of an HMO's problems and urges the HMO to develop and implement a corrective action plan. If the HMO does not implement the corrective action or the action is inadequate, HCFA staff investigate the HMO's operations and further document the problems. An investigation could result in HCFA finding noncompliance and requesting a new corrective action plan.

Without prompt and forceful HCFA action, years can pass before an HMO corrects identified problems. For example, in the South Florida case we reviewed, in which a PRO had raised concerns about the quality of care provided by the HMO in 1991 and again in 1992,

HCFA did not probe into the problem until 1994, when it formed a special investigation team that found the HMO's quality assurance and utilization management systems did not meet federal standards. From 1988 to 1994, the HMO enrolled over 336,000 beneficiaries, while about 269,000 disenrolled; in 1994, the HMO had Medicare revenues of over \$1 billion.

SLOW APPEAL PROCESS PLACES  
BENEFICIARIES AT RISK

Weaknesses in HCFA's monitoring and enforcement actions increase the importance of the appeal process for resolving disputes about HMO denials of care. The appeal process, however, often has been too slow to effectively resolve disputes over services that beneficiaries believe they urgently need. To receive such care, some beneficiaries disenroll and return to fee-for-service Medicare. Others remain in HMOs but incur substantial out-of-pocket costs with little certainty of repayment.

Under Medicare rules, beneficiaries may appeal HMO denials of service, including refusals to pay for services obtained outside the plan when there was an emergency or urgent need for care. If an HMO appeal panel rules against a beneficiary, it must forward the case to HCFA. Under current HCFA standards, this first level in the appeal process--from the initial denial of care to the forwarding of the appealed case to HCFA--can take up to 6 months. Although HCFA strives to resolve appeals it receives within 30 days, most cases took longer. In 1993, only 38 percent of the cases were decided within 30 days, and 45 percent required about 3-1/2 months. More complex cases, where medical information was missing or Medicare coverage rules were unclear, took over 6 months.

Some beneficiaries who obtain out-of-plan services that they believe are needed may be liable for those costs. In 1994, 80 percent of the 3,100 appeals reviewed by HCFA involved denied claims for reimbursement of services obtained from providers not affiliated with the HMO. The average claim was about \$4,300, totaling over \$15 million in disputed claims. HCFA decided against beneficiaries 64 percent of the time, leaving them liable for more than \$11 million in claims.

HCFA has taken steps toward improving the appeal process. In November 1994, HCFA clarified its rules to permit appeal without a written denial notice from the plan. HCFA also issued a rule in November 1994 extending to beneficiaries in HMOs the right to expedited PRO review of HMO decisions to discharge them from a hospital when they believe they should remain hospitalized--a right that fee-for-service Medicare beneficiaries have had since 1986. In addition, HCFA operations officials recognize the potential for further improvements.

## PRIVATE SECTOR DEVELOPMENTS SUGGEST ALTERNATIVE STRATEGIES TO ENSURE QUALITY

Private sector employers, as sponsors in selecting their employees' health plans, have developed strategies for ensuring quality and value in HMO selection, including demanding accreditation reviews, collecting more information on HMO performance, and providing the information to consumers. HCFA is the Medicare beneficiaries' sponsor in certifying and overseeing Medicare contract HMOs. HCFA, however, does not routinely provide beneficiaries the results of its monitoring reviews or other performance-related information it collects, such as HMO disenrollment rates or beneficiary complaints. Private sector strategies provide models for improving federal oversight of Medicare HMOs.

Some large employers, as sponsors of their employees, have begun to use accreditation and performance data in deciding whether to accept an HMO into their plan. By the end of 1995, nearly half the HMOs in the country will have undergone National Committee for Quality Assurance (NCQA) accreditation review. NCQA accreditation focuses primarily on HMO quality assurance practices that are related to medical operations--the area in which federal certification reviews are relatively weak. NCQA's accreditation review teams typically include physicians and other clinicians or administrators experienced in HMO operations

In addition, a group of large employers and HMOs working with NCQA have developed the Health Plan Employer Data and Information Set (HEDIS), a standardized information database that can enable consumers--both group and individual--to compare different HMOs. HEDIS includes data on various plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. HCFA recently embraced this approach and proposes to develop, in cooperations with NCQA, HEDIS-type HMO performance measures geared to elderly Medicare beneficiaries.

The private sector also disseminates quality-related information to purchasers and users. NCQA publicizes its accreditation decisions for employers and employees to consider in their HMO selection. Consequently, HMOs that do not obtain accreditation can lose business. For example, when a Florida HMO failed to get NCQA accreditation, a consortium of employers elected to exclude the HMO from new business with their employer-sponsored health plans.

## CONCLUSIONS

Over the past two decades the federal government's leadership position regarding HMOs and quality assurance has declined relative to the private sector. In the early 1970s, the federal government encouraged the growth of HMOs and developed the standards for

assuring quality of care. Since the mid-1980s, however, HCFA's approach to quality assurance and other beneficiary protections in Medicare contract HMOs has been unresponsive. Quality assurance problems have gone undetected or, when detected, have not been acted on promptly. By contrast, the private sector has become more active in monitoring quality assurance and holding HMOs accountable for their performance.

Preliminary evidence on the success of private sector approaches--coupled with the long history of weaknesses in HCFA's monitoring and enforcement of HMOs--suggests that HCFA could and should become a more active, consumer-oriented sponsor for Medicare beneficiaries enrolled in HMOs. This would entail

- using qualified personnel to do routine monitoring, and including PRO findings in HCFA's evaluations of HMO compliance;
- using the option of discontinuing enrollment to minimize beneficiary exposure to noncompliant HMOs;
- providing Medicare beneficiaries such basic information as disenrollment data, complaint rates, and HMO compliance status to help them in choosing health care providers; and
- streamlining the process for appealing coverage decisions to minimize beneficiaries' risk of incurring high out-of-pocket costs.

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This concludes my prepared statement. I will be happy to answer any questions that you may have.

For more information on this testimony, please call Edwin Stropko, Assistant Director, at (202) 512-7108. Other major contributors included Charles A. Walter, Lourdes R. Cho, and Karen Sloan.



RELATED GAO PRODUCTS

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

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

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

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

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

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

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

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

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

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

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

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