DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 27 1992

From Richard P. Kusserow
Inspector General

Subject Follow-up Audit of General Accounting Office Report "Medicare - Reasonableness of Health Maintenance Organization Payments Not Assured" (A-14-92-00371)

To William Toby
Acting Administrator
Health Care Financing Administration

Attached is the report on our follow-up audit of the General Accounting Office (GAO) report entitled, "Medicare - Reasonableness of Health Maintenance Organization Payments Not Assured" (GAO/HRD-89-41). The objective of our follow-up review was to ensure that the specific audit recommendations unconditionally accepted by the Health Care Financing Administration were satisfactorily implemented or appropriately resolved.

The GAO made seven recommendations in its final report issued March 7, 1989. Comments from the Department of Health and Human Services (HHS) dated November 7, 1988 were included in the GAO final report. In accordance with the requirements of the Office of Management and Budget's Circular A-50, HHS furnished an additional response to the report on August 23, 1989.

Our review showed that HHS either has implemented or is implementing six of the seven GAO recommendations. The remaining recommendation was not accepted by HHS. It involved placing a health maintenance organization under a corrective action plan if it used inappropriate data in preparing its adjusted community rate proposal. The HHS responded by stating that it would explore what would have to be done to establish the criteria for a corrective action plan.

If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at FTS 646-7104. We would appreciate receiving your comments within 60 days from the date of this memorandum.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP AUDIT OF GENERAL ACCOUNTING OFFICE REPORT "MEDICARE - REASONABLENESS OF HEALTH MAINTENANCE ORGANIZATION PAYMENTS NOT ASSURED"

Richard P. Kusserow
INSPECTOR GENERAL

A-14-92-00371

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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Subject Follow-up Audit of General Accounting Office Report "Medicare - Reasonableness of Health Maintenance Organization Payments Not Assured" (A-14-92-00371)

To William Toby
Acting Administrator
Health Care Financing Administration

This report summarizes the results of our follow-up review of a 1989 General Accounting Office (GAO) audit report entitled, "Medicare - Reasonableness of Health Maintenance Organization Payments Not Assured" (GAO/HRD-89-41). The purpose of our follow-up review was to ensure that the specific audit recommendations unconditionally accepted by the Department of Health and Human Services (HHS) were satisfactorily implemented or appropriately resolved.

In its final report issued March 7, 1989, GAO made seven recommendations. Our review showed that the six GAO recommendations accepted by HHS either have been implemented or are being implemented. One recommendation was not accepted by HHS. It involved having the Health Care Financing Administration (HCFA) place a health maintenance organization (HMO) under a corrective action plan when the HMO uses inappropriate data to prepare its adjusted community rate (ACR) proposal. Our report is issued pursuant to the Office of Inspector General's (OIG) responsibilities under Office of Management and Budget (OMB) Circular A-50 to review and report on management responses to audit findings.

INTRODUCTION

BACKGROUND

Medicare, administered by HCFA within HHS, is a health insurance program that assists most elderly aged 65 or

older and certain disabled people in paying for their health care. The program is authorized under Title XVIII of the Social Security Act.

During 1972, HMOs operating under either cost or risk contracts were authorized to serve Medicare beneficiaries on a prepaid basis under section 1876 of the Social Security Act. Under cost contracts, HMOs are paid the actual costs of providing services to Medicare beneficiaries. Under risk contracts, HMOs are paid fixed monthly amounts per beneficiary based on adjusted average per capita rates (AAPCC). The AAPCC rates are actuarial estimates of what Medicare would incur, on average, for serving HMO enrollees if they remained in the fee-for-service sector. An average payment rate (APR) is calculated which is the amount an HMO expects to receive from Medicare. The APR is based on AAPCC rates and the numbers and categories (such as age, gender, institutional status, etc.) of enrolled beneficiaries.

As a safeguard, Medicare law provides for the ACR process to help ensure the accuracy of HCFA's AAPCC rates. The ACR is calculated by HMOs and is an estimate of what they would charge Medicare beneficiaries for Medicare-covered services if the beneficiaries were commercial enrollees. If the APR is greater than the ACR, the savings must either be returned to Medicare or program beneficiaries. If the APR is less than the ACR, the loss must be absorbed by the HMO.

The GAO audited the ACR process because of continuing concerns about the adequacy of the AAPCC method of setting reasonable HMO payment rates. The purpose of GAO's review of the ACR process was to assess the degree to which the process effectively ensures a fairly priced package of benefits for Medicare enrollees.

SCOPE

In consonance with OIG policies and procedures, the limited objective of our follow-up review was to ensure that the specific GAO audit recommendations unconditionally accepted by HHS were satisfactorily implemented or appropriately resolved. We obtained and reviewed the ACR guidelines issued to the HMOs during September 1989 for the 1990 contract year. These guidelines were used to help evaluate the extent to which HCFA took appropriate corrective action with regard to the GAO recommendations.

The GAO audit report included seven distinct recommendations. Our review included a follow-up of HCFA's responses only on the six GAO recommendations accepted by HHS. The remaining recommendation was not accepted by HHS and was therefore excluded from our review.

Our fieldwork was completed during Fiscal Year 1991 at HCFA's headquarters in Baltimore, Maryland. Our review was performed in accordance with generally accepted Government auditing standards, except that we did not review the GAO working papers pertaining to its audit nor did we review HCFA's internal controls over the receipt, evaluation and implementation of recommendations contained in GAO audit reports. Our review was made pursuant to requirements for audit follow-up included in OMB Circular A-50.

RESULTS

SPECIFIC RECOMMENDATIONS

Based on the review of ACRs submitted by 19 HMOs from 1985 through 1987, GAO concluded that the ACR process is not meeting its potential as a payment safeguard. The GAO audit report contained seven recommendations.

Our review showed that the six recommendations accepted by HHS have been implemented or are being implemented. Specifically, in response to GAO recommendations:

- HCFA's instructions now require HMOs to submit their ACR proposals in a standard format on a floppy disk;
- HMOs are required to use both volume and intensity factors in computing their ACRs;
- HCFA's instructions now stipulate the conditions under which HMOs are permitted to use cost and utilization data other than their own;
- HCFA has developed and tested a protocol for reviewing ACRs during on-site visits at HMOs;

- HMOs now submit signed certifications of the accuracy of data used in preparing their ACRs; and

- HHS agreed to revise regulations to authorize HCFA to recoup from an HMO any excess payments.

Details on the six recommendations unconditionally accepted by HHS, comments from HHS, and our review of the actions taken on the recommendations are shown in Appendix A. For informational purposes, the one GAO recommendation which HHS has not accepted and HHS' reply is listed in Appendix B.

CONCLUSION

Our follow-up review showed that HCFA has taken appropriate action on all six of GAO's recommendations with which it had concurred. For this reason, we are not making specific recommendations with respect to the programmatic areas included in GAO's scope of audit.

STATUS OF GAO RECOMMENDATIONS

AGREED TO BY HHS

The following are the six GAO recommendations that HHS concurred with, comments from HHS, and our review of the actions taken on the recommendations.

GAO RECOMMENDATION 1

The GAO found inconsistencies in the format used by HMOs to prepare their ACRs. These inconsistencies make comparisons of an HMO's categories from one year to the next and to other HMOs more difficult, and in some cases, impossible. To reduce inconsistencies and to more easily detect inconsistencies, the GAO recommended that the Secretary of HHS direct the Administrator of HCFA to revise instructions to HMOs to require the use of a standardized ACR submission. The HHS responded that it agreed with the GAO recommendation and stated that it would require HMOs to submit standardized ACRs for the 1990 contract year.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 1

Recommendation 1 has been implemented. To standardize ACR submissions beginning with the 1990 contract year, HCFA's August 1989 instructions require HMOs to submit their ACR proposals in a standard format on a floppy disk. We verified that HMOs, which HCFA approved for the 1990 contract year, submitted their ACRs using the standard format.

GAO RECOMMENDATION 2

The GAO found that many of the HMOs reviewed were not complying with the requirement that both a volume and an intensity adjustment be used in calculating factors for ACR service categories. Also, many of the ACRs reviewed lacked adequate documentation concerning the source of utilization data used, the methodology used, and the calculations used to arrive at an estimated rate. The GAO recommended that the Secretary of HHS direct the Administrator of HCFA to revise the instructions to HMOs on preparing ACR submissions. These revised instructions should require that HMOs use both volume and intensity adjustments to calculate utilization factors and adequately document the basis for the factors used.

The HHS agreed with the GAO recommendation and stated that it would issue instructions to the HMOs to use both volume and intensity factors in computing their ACRs. In

addition, HHS stated that it would have HCFA compute its own database of volume and intensity factors from health plans that used their own data. If a health plan did not want to use its own statistics, it would be required to use the volume and intensity factors from HCFA's database.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 2

Recommendation 2 has been implemented. The HCFA issued Transmittal IM-88-2, dated October 1988, as well as instructions dated September 1989, requiring HMOs to use both volume and complexity factors and to document the basis for the factors used in preparing their ACRs. Additionally, the instructions state that "...HCFA has created a database based on the experience of other risk contractors..." for use by HMOs which do not have their own data to prepare the ACRs. Requests to use the HCFA database must be in writing.

GAO RECOMMENDATION 3

The GAO found that many of the HMOs reviewed did not always use their own data to prepare their ACRs. Also, HMOs changed from one published source of data to another from 1 year to the next without documenting the rationale. The GAO recommended that the Secretary of HHS direct the Administrator of HCFA to revise its instructions to HMOs on preparing their ACRs. The instructions should indicate the conditions under which HMOs may use cost and utilization data other than their own for computing ACRs.

The HHS agreed with the GAO recommendation and responded by stating that written guidelines would be established to specify those instances in which renewing plans must use their own cost and utilization statistics in preparing ACRs.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 3

Recommendation 3 has been implemented. September 1989 instructions from HCFA to HMOs stipulate the conditions under which HMOs are permitted to use cost and utilization data other than their own.

GAO RECOMMENDATION 4

The GAO found that HCFA only made monitoring visits to 29 percent of the 154 risk contract HMOs during the 3 years ending December 1987. Further, the visits usually lasted only day and the scope of work was generally insufficient to verify the reasonableness of ACR submissions. The GAO recommended that the Secretary of HHS direct the Administrator of HCFA to establish policies and procedures to periodically conduct on-site reviews of HMOs to verify the accuracy and reasonableness of the data supporting their ACRs against their records and accounting system reports.

The HHS agreed with the GAO recommendation and responded by stating that it would incorporate on-site monitoring of premium development into its existing HMO on-site monitoring program.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 4

This recommendation is being implemented. The Office of Prepaid Health Care, within the Office of Compliance, furnished us with a draft copy of HCFA's proposed protocol for reviewing ACRs during on-site visits at the HMOs.

Our discussions indicate that HCFA planned to test the protocol during the 1990 contract year to determine staff training requirements. The final protocol was to be implemented during the 1991 contract year.

GAO RECOMMENDATION 5

The GAO found that HMOs did not certify the accuracy of the data used in preparing their ACRs. The GAO recommended that the Secretary of HHS direct the Administrator of HCFA to revise HCFA regulations and incorporate provisions in HMO contracts to require that HMOs certify the accuracy and reasonableness of their ACR submissions.

The HHS agreed with the GAO recommendation and will require HMOs to certify the accuracy of the data used in preparing the ACRs.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 5

Recommendation 5 has been implemented. Our review showed that HMOs submitted a signed certification of the accuracy of data used in preparing their 1990 ACRs.

GAO RECOMMENDATION 6

The GAO found that HCFA did not have authority to recoup overpayments made because HMOs used unauthorized methods or data to prepare their ACRs. The GAO recommended that the Secretary of HHS direct the Administrator of HCFA to revise regulations to authorize HCFA to recoup from an HMO any excess payments resulting from HMOs using data that were not accurate, current, or complete.

The HHS concurred that regulations should be revised to authorize HCFA to recoup from an HMO any excess payments.

OFFICE OF AUDIT SERVICES' REVIEW OF RECOMMENDATION 6

Recommendation 6 has not been implemented. We discussed the recoupment of excess payments with staff of the Office of Financial Management within the Office of Compliance, and the Policy, Planning and Liaison Office within the Office of Prepaid Health Care. We found no evidence that a change in regulations was being pursued. However, during our review, the Acting Director of the Policy, Planning and Liaison staff stated that they would be developing the change in the regulations to implement the GAO recommendation.

GAO RECOMMENDATION

NOT AGREED TO BY HHS

The GAO report "Medicare - Reasonableness of Health Maintenance Organization Payments Not Assured" contained seven recommendations. This appendix shows the recommendation which HHS did not accept.

GAO RECOMMENDATION

"That the Secretary of HHS direct the Administrator of HCFA to revise its instructions to HMOs on preparing ACR submissions to ...establish a requirement that HMOs not able to...[stipulate the conditions under which they would use cost data other than their own] and not having complete data to support their ACR submissions be placed under a corrective action plan as a condition for contract renewal."

HHS' RESPONSE TO GAO RECOMMENDATION

Responding to the draft GAO report, HHS stated: "As for those plans refusing to abide by these guidelines, we are exploring what would have to be done to establish the criteria for a corrective action plan and to consider the criteria during contract renewal."