DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 14 1999

From June Gibbs Brown
Inspector General

Subject Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care (A-07-98-01256)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled "Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care." Our objective was to review inpatient services paid by Medicare under traditional fee-for-service after the beneficiaries disenrolled from managed care risk plans. This review was part of our ongoing work to assess whether Medicare risk plans were selectively enrolling healthier beneficiaries and encouraging sicker beneficiaries to disenroll.

We selected six managed care firms for this initial audit. Our review of beneficiaries who disenrolled from these six risk plans during 1991 through 1996 found that:

- Medicare paid hospitals $224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment.
- Medicare would have paid $20 million in capitation payments to these six firms had these beneficiaries not disenrolled, a difference of $204 million.
- About 18 percent of the expenditures ($41 million) were paid for beneficiaries who reenrolled in Medicare managed care after receiving the inpatient care under the Medicare fee-for-service program.

Based on our analyses, it appeared that risk plans could avoid significant payments for medical services by having sicker beneficiaries disenroll, have medical service performed under the Medicare fee-for-service program and then reenroll the beneficiary when they are again healthy. The loser in this scenario is the Medicare program and the related Trust Funds.

We are currently undertaking specific audit/investigative work related to enrollment/ disenrollment actions at some of the managed care plans. As our analysis continues, we believe the process we followed could be useful to the Health Care Financing Administration (HCFA) in evaluating health maintenance organization (HMO) performance.

With the passage of the Balanced Budget Act (BBA) of 1997, risk-based managed care plans are required to submit medical services encounter data to HCFA beginning in 1998. This information will help HCFA assess HMO performance. With the implementation of BBA, HCFA should consider including an evaluation of the services provided to beneficiaries both before and after disenrollment as a part of its monitoring system. Therefore, we recommended that HCFA assess patients' health status after disenrollment as a part of its Contractor Performance Monitoring System used in evaluating the Medicare managed care program.

It should be noted that we reviewed only inpatient services performed after disenrollment. Our review did not include the services provided to beneficiaries while enrolled at the six risk plans, nor did it include services provided after disenrollment by home health agencies, skilled nursing facilities, outpatient services, or Medicare Part B services. We plan to continue our review into the nature and effects of HMO disenrollments, both to the Medicare program and to its beneficiaries.

In responding to the draft report, HCFA agreed that *...there was a problem with disenrollment just prior to receiving expensive inpatient services.* A study of disenrollment issues funded by HCFA produced similar results to those found in this report. The HCFA further stated the Office of Inspector General findings *...raised important issues regarding quality of care in managed care and certainly suggest the need for further investigations and careful monitoring of the managed care environment.*

With respect to our recommendation, HCFA is in the early planning stages of a study which will examine the reasons beneficiaries disenroll prior to a fee-for-service hospitalization. Additionally, HCFA is developing several disenrollment measures, including a disenrollment survey and a system *that will examine trends in disenrollment by health status*. The HCFA also commented on several technical issues pertaining to the need to more fully understand why beneficiaries disenrolled and whether or not the HMOs and related physicians had a negative influence on the beneficiaries which caused them to disenroll. We agree with HCFA's comments and are involved in other reviews to address these questions. The complete text of HCFA's response is presented as Attachment F to this report.

In addition to its studies and other efforts, we believe HCFA should include an assessment of patients' health status both before and after disenrollment as a part of its monitoring system. In further audit/investigative work, we intend to address the technical issues raised by HCFA. We look forward to working with HCFA to obtain a further understanding of the disenrollment issues as the managed care environment evolves further.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-07-98-01256 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INPATIENT SERVICES PERFORMED ON BENEFICIARIES AFTER DISENROLLING FROM MEDICARE MANAGED CARE

JUNE GIBBS BROWN
Inspector General

MAY 1999
A-07-98-01256

Memorandum

Date MAY 14 1999

From June Gibbs Brown
Inspector General

Subject Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care (A-07-98-01256)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report presents the results of our review of Medicare inpatient services paid for beneficiaries shortly after they disenrolled from Medicare managed care risk plans. This review was part of our ongoing work to assess whether Medicare risk plans may be selectively enrolling healthier beneficiaries and encouraging sicker beneficiaries to disenroll.

We selected six managed care firms for this initial audit. Our review of beneficiaries who disenrolled from these six risk plans during 1991 through 1996 found that:

- Medicare paid hospitals $224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment.
- Medicare would have paid $20 million in capitation payments had these beneficiaries not disenrolled, a difference of $204 million.
- About 18 percent of the $224 million in expenditures ($41 million) were paid for beneficiaries who reenrolled in Medicare managed care after receiving the inpatient care under the Medicare fee-for-service program.

We are currently undertaking specific audit/investigative work related to enrollment/ disenrollment actions at some of the managed care plans. As our analysis continues, we believe the process we followed to this point could be useful to the Health Care Financing Administration (HCFA) in evaluating health maintenance organizations' (HMO) performance. Therefore, we recommended that HCFA assess patients' health status after disenrollment from an HMO as a part of HCFA's Contractor Performance Monitoring System (CPMS) which is used in evaluating the Medicare managed care program.

With the passage of the Balanced Budget Act (BBA) of 1997, risk-based managed care plans are required to submit medical services encounter data to HCFA beginning in 1998. This information will help HCFA assess HMO performance. The HCFA should use this

information in evaluating HMO services provided to beneficiaries both before and after disenrollment as a part of its monitoring system. We recommended that HCFA assess patients' health status after disenrollment as part of its CPMS used in evaluating the Medicare managed care program.

In responding to the draft report, HCFA agreed that *...there was a problem with disenrollment just prior to receiving expensive inpatient services.* A study of disenrollment issues funded by HCFA produced similar results to those of the Office of Inspector General (OIG). The HCFA further stated the OIG findings *...raised important issues regarding quality of care in managed care and certainly suggest the need for further investigations and careful monitoring of the managed care environment.*

With respect to the OIG recommendation, HCFA is in the early planning stages of a study which will examine the reasons beneficiaries disenroll prior to a fee-for-service hospitalization. Additionally, HCFA is developing several disenrollment measures, including a disenrollment survey and a system *that will examine trends in disenrollment by health status.* The HCFA also commented on several technical issues pertaining to the need to more fully understand why beneficiaries disenrolled and whether or not the HMOs and related physicians had a negative influence on the beneficiaries which caused them to disenroll. We agree with HCFA's comments and are involved in other reviews to address these questions. The complete text of HCFA's response is presented as Attachment F to this report.

In addition to its studies and other efforts, we believe HCFA should include an assessment of patients' health status both before and after disenrollment as a part of its monitoring system. In further audit/investigative work, we intend to address the technical issues raised by HCFA.

We look forward to working with HCFA to obtain a further understanding of the disenrollment issues as the managed care environment evolves further.

BACKGROUND

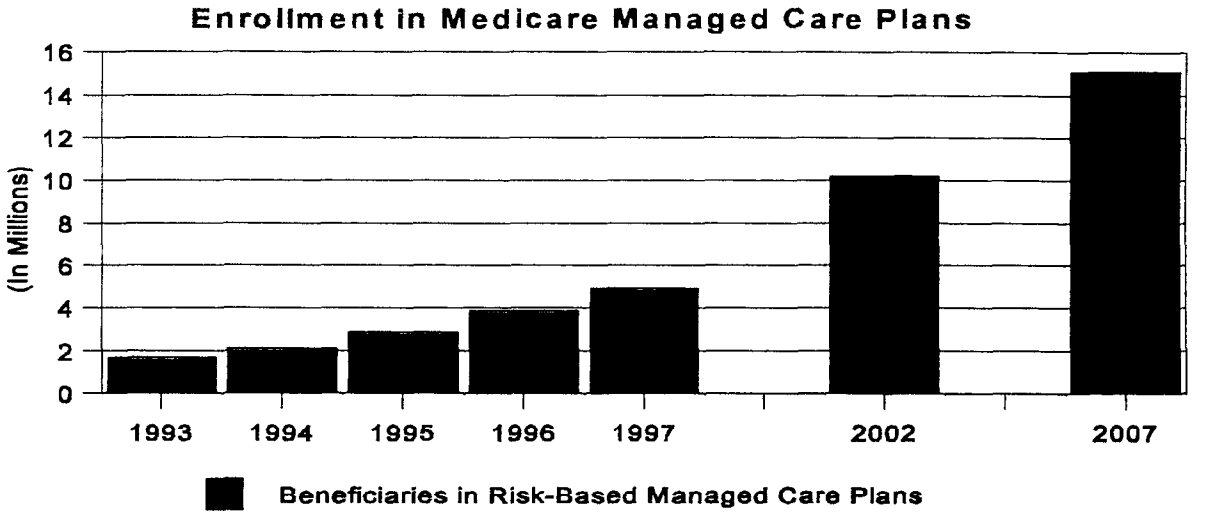
Managed care is defined as a health delivery and payment structure in which the payer organization seeks to control costs and maintain uniform quality of care by exercising specific controls over treatment and fees charged by the providers, who agree to participate in a given health plan. Managed care concepts have helped private sector payers contain health care costs and limit excess utilization encouraged by fee-for-service reimbursement methodologies. Thus, the Congress recognized the potential cost-control advantages of managed care and enacted legislation to incorporate managed care options into the Medicare program.

Legislation allowed Medicare to contract with managed care organizations on a cost reimbursement basis since 1972. The Medicare managed care risk program dates back to 1982 when the Congress enacted the Tax Equity and Fiscal Responsibility Act. This

legislation was implemented in 1985 and gave Medicare beneficiaries the option to enroll in risk-based plans. Under the Medicare risk-based program, plans must assume responsibility for providing all Medicare-covered services in return for a predetermined capitated payment. Prior to this, Medicare managed care plans were reimbursed for their costs through a cost report settlement process.

Since 1985, the Medicare risk program has steadily grown. Realizing the cost-control appeal, as well as potential advantages to beneficiaries, HCFA encouraged managed care organizations to contract on a risk basis. Most plans which contract with HCFA today do so on a risk basis. In December 1997, there were 417 Medicare managed care plans — 307 of which were risk-based contracts. The remainder included cost reimbursement contracts and various types of partial capitation arrangements such as plans covering only Medicare Part B services.

As shown in the graph below, the steady increase of enrollment in managed care plans is expected to continue.



During 1993, there were approximately 2.5 million beneficiaries enrolled in managed care, of which 1.7 million were in risk-based plans. In December 1997, there were approximately 5.9 million Medicare beneficiaries enrolled in managed care with 5.2 million in risk-based plans, or approximately 14 percent of all Medicare beneficiaries. The Congressional Budget Office estimates that the number of Medicare beneficiaries who receive their medical care through risk plans will rise to 34 percent (15.1 million) by 2007.

Except for beneficiaries with end stage renal disease and those eligible for hospice care, risk plans must enroll any eligible Medicare beneficiary who contacts them. According to 42 CFR, sections 417.101 and 417.414, risk plans must provide or arrange for the required Medicare services, and any additional or supplemental services the Medicare beneficiary is entitled to receive as part of the managed care enrollment. These services are to be delivered by Medicare approved providers and suppliers as needed and without limitations as to time and cost. Likewise, the beneficiaries cannot be disenrolled involuntarily for medical reasons.

Once enrolled, beneficiaries are locked-in to the physicians and hospitals arranged through the risk plan. Other than emergency services, the cost of deviations from those providers are the responsibility of the beneficiary, not Medicare or the plan.[1] To ensure Medicare beneficiaries receive proper medical services, the plans must have a quality assurance program. Specifically, 42 CFR, section 417.106 stated that each risk plan:

> *. . . must have an ongoing quality assurance program for its health services that meets the following conditions:*
>
> *(1) Stresses health outcomes to the extent consistent with the state of the art.*
>
> *(2) Provides review by physicians and other health professionals of the process followed in the provision of health services.*
>
> *(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change.*
>
> *(4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.*

The HCFA monitors activities of the risk plans using the CPMS. This system includes reviews designed to analyze, among other things, quality assurance programs of the risk plans to ensure compliance with the CFR requirements. Additionally, HCFA reviews the risk plans' incentive arrangements to ensure that they *do not include any specific payment to be made directly or indirectly to a physician or physician group as an inducement to withhold, limit, or reduce services to a specific enrollee.*

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[1]The Balanced Budget Act authorized a new program entitled Medicare+Choice which modifies the lock-in provisions and out-of-network usage of providers. These changes were effective January 1999.

SCOPE

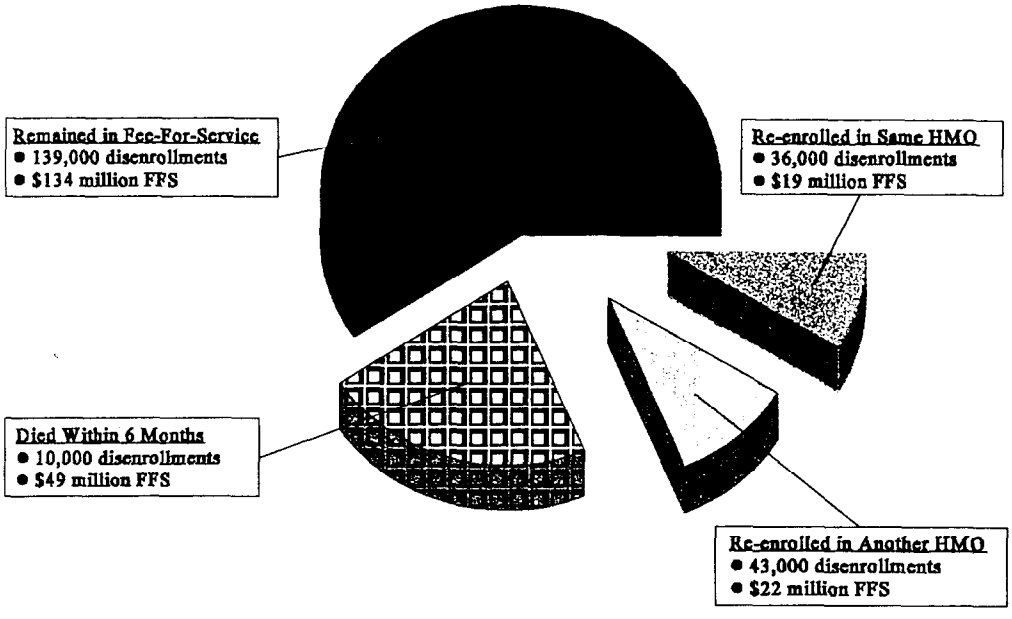
We performed our review in accordance with generally accepted government auditing standards. Our objective was to review the inpatient services paid by Medicare under traditional fee-for-service after the beneficiaries disenrolled from managed care risk plans. We examined data for those beneficiaries who disenrolled during 1991 through mid-1996 from each of the six risk plans to Medicare fee-for-service. The plans were judgementally selected. Criteria used included total disenrollments compared to nationwide totals, geographic location, and death rates for disenrolled persons. This review was performed from October 1996 through July 1998 at the regional Office of Audit Services in Kansas City. Our initial work was extended and our reporting of the results was delayed as a result of discussions we had with investigative staff interested in pursuing some of these cases for improper disenrollment actions.

In analyzing the managed care enrollment and disenrollment dates, we used data from the HCFA Group Health Plan System. The hospital inpatient claims analysis involved accessing the HCFA inpatient Standard Analytical Files. Our review compared the dates on the inpatient claims to the dates of enrollments and disenrollments from the six managed care plans. We limited our review to those fee-for-service claims with admissions within 3 months of disenrollment. For presentation purposes all numbers in the report are rounded.

RESULTS OF REVIEW

Medicare paid hospitals about $224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment from the six risk plans we studied. Had the beneficiaries who received the services remained in the managed care plans during the period that the fee-for-service work was claimed, Medicare would have paid about $20 million to the managed care plans in the form of monthly capitation payments. The $204 million difference represents funds Medicare could have saved if the beneficiary had remained in the plan. It was also interesting to note that about 18 percent of the $224 million of fee-for-service payments ($41 million) was related to beneficiaries who disenrolled from the HMO, had treatment under fee-for-service and then reenrolled in an HMO--but not necessarily the same HMO from which they disenrolled. An additional 20 percent of the fee-for-service payments ($49 million) was related to beneficiaries who died within 6 months of their disenrollment from the HMO. The following chart displays our results by beneficiaries who: (1) died within 6 months after disenrolling, (2) remained in fee-for-service after the disenrollment action, (3) reenrolled in another HMO, or (4) reenrolled in the same HMO.

Inpatient Services After Disenrollment



Because of the significant payments to hospitals within 3 months of the disenrollment action for beneficiaries not returning to managed care, and the high percentage of beneficiaries reenrolling after receiving inpatient services through fee-for-service, we plan a further examination of the relationships between the hospitals, physicians, and the risk plans.

Relationships of Enrollments to Disenrollments

While enrollments in Medicare managed care experienced unprecedented growth, disenrollments also occurred in substantial numbers. At the six plans we reviewed, total net enrollment increased from 471,000 to 893,000 during 1991 through 1996. During this period, however, there were 1,053,000 new enrollments and 631,000 disenrollments. Comparing enrollments and disenrollments, we found that:

- for the six risk plans, the ratio of net enrollments to disenrollments was 1.7 to 1.
- for all plans nationwide, this ratio was 2.5 to 1.

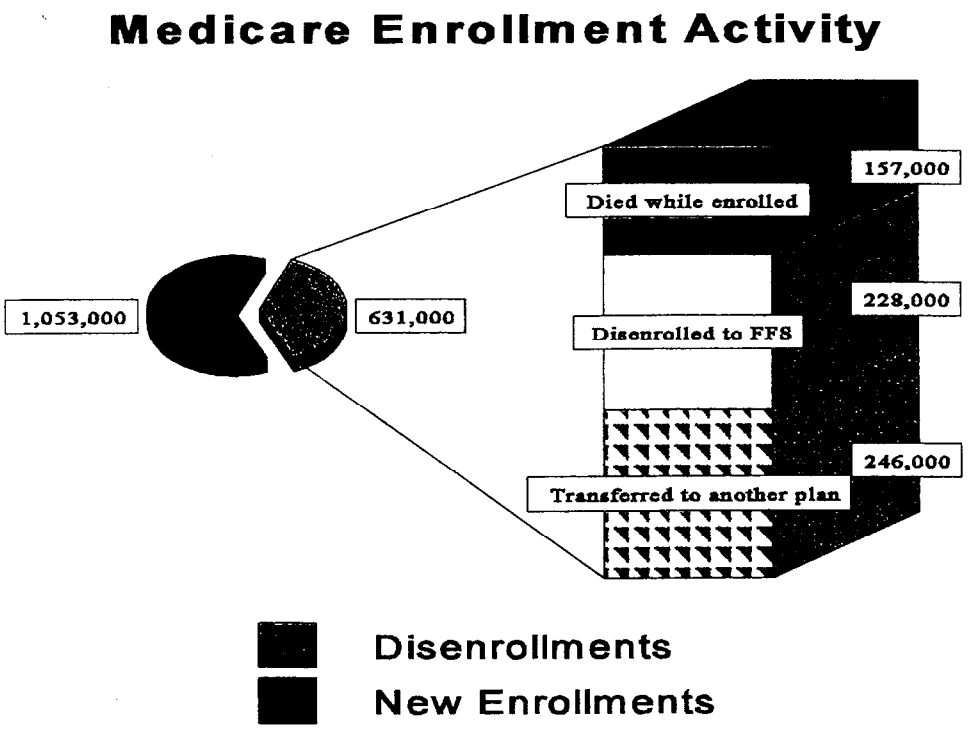
(see Attachment A for additional details)

These ratios do not of themselves indicate wrongdoing by these six plans. However, a ratio closer to a 1:1 ratio of enrollments to disenrollments should be an indicator to review a

plan for possible problems with medical service delivery since so many beneficiaries decided to disenroll. It could be an indicator that beneficiaries leave the plans because adequate services are not being delivered.

The following graph illustrates the number of enrollments and disenrollments for the six plans we reviewed. It also separates the disenrollments into three categories: died while enrolled; disenrolled to fee-for-service (FFS); and transferred to another plan.

1991 BEGINNING MEDICARE ENROLLMENT: 471,000



1996 ENDING MEDICARE ENROLLMENT: 893,000

Inpatient Expenditures Avoided

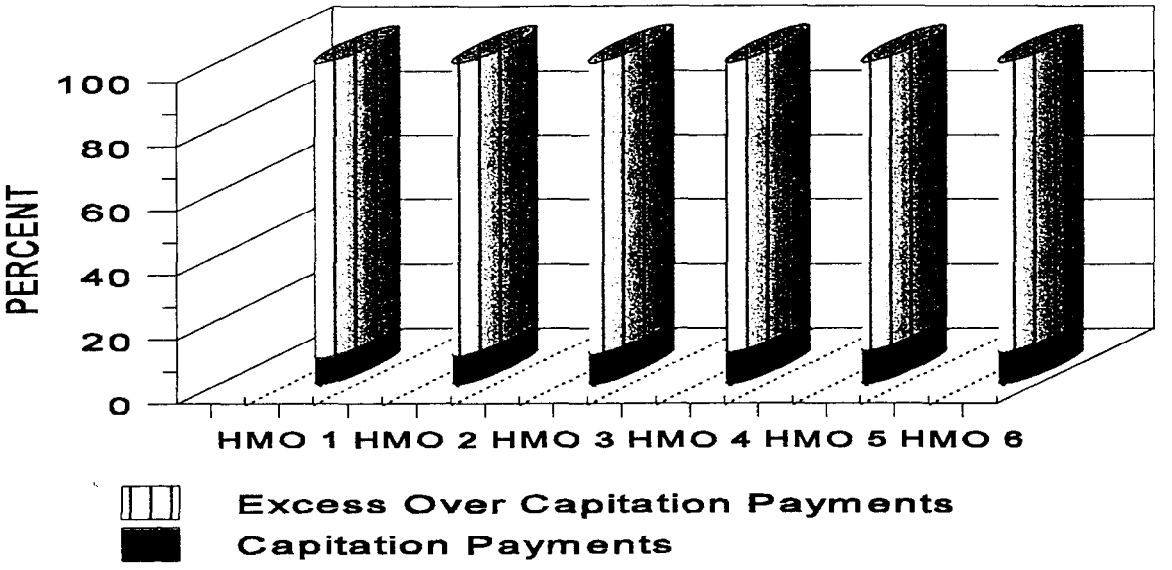
Aggregate Payments to Hospitals

Medicare paid hospitals fee-for-service payments amounting to about $224 million for inpatient services (see Attachment B) furnished to beneficiaries within 3 months of their disenrollment from the six risk plans studied. Had these beneficiaries remained in the six plans during this 3-month period, Medicare would have paid approximately $20 million (see Attachment C) in capitation payments, a difference of $204 million (see Attachment D).

The following chart shows that of the $224 million paid for inpatient services provided within 3 months, about $89 million was for services in the first month after disenrolling. Had these beneficiaries remained in the six risk plans for that one additional month, Medicare would have paid approximately $4 million in capitation payments, a difference of $85 million.

Amount Paid to Inpatient Hospitals Within 1 Month of Disenrolling (in thousands)							
HMO/ Year	**1991**	**1992**	**1993**	**1994**	**1995**	**1996 - ❶**	**Total**
HMO 1	$1,610	$2,384	$3,351	$3,882	$4,652	$3,720	$19,599
HMO 2	4,185	4,201	3,438	5,009	4,529	3,526	24,888
HMO 3	5,936	7,907	8,179	6,977	7,347	4,338	40,684
HMO 4	233	211	335	130	566	97	1,572
HMO 5	79	150	229	240	288	313	1,299
HMO 6	0	0	0	233	423	1,046	1,702
Total	$12,043	$14,853	$15,532	$16,471	$17,805	$13,040	$89,744

The following graph compares the percentage of capitation payments and the amount Medicare paid for inpatient services within 3 months of disenrolling from the six risk plans we studied. In all cases, the capitation payments that Medicare would have paid the six risk plans are less than 10 percent of total fee-for-service expenditures for inpatient services that were incurred after the disenrollments.



Individual Case Examples

Specific examples of inpatient services provided to beneficiaries within 3 months of their disenrollment, from the six HMOs we reviewed, are discussed in the following paragraphs. Under separate audits and/or investigations, we are performing additional analysis of these cases and the associated risk plans.

- A beneficiary was enrolled in the same HMO for 6 years. The individual disenrolled from the plan in June 1992 and was admitted to a hospital as a fee-for-service patient on August 18, 1992. Prior to discharge from the hospital, the beneficiary reenrolled in the same HMO on October 1, 1992. Because the beneficiary was hospitalized in fee-for-service at the time of reenrollment, Medicare's fee-for-service program was obligated to pay the $97,000 for the treatment (tracheostomy except for face, mouth, and neck diagnosis) even though the beneficiary was not discharged until November 19, 1992. Had the beneficiary remained in the HMO continuously, as they had for 6 years, to include the period July through September, Medicare's capitation payments would have been $900 for those 3 months. By the beneficiary disenrolling, the HMO avoided $96,100 in expenditures.

* Hospital Cost	$ 97,000
* Capitation	$ 900
* Avoided	$ 96,100

- After 6 months in an HMO, a beneficiary disenrolled in June 1995 and was admitted into a hospital on September 6, 1995. Inpatient services for a craniotomy were provided and Medicare paid $23,000 through the fee-for-service program. This

beneficiary subsequently reenrolled in the same HMO in October 1995. If the beneficiary would not have disenrolled, Medicare would have paid the HMO approximately $1,000 in capitation payments.

- A beneficiary, enrolled in an HMO for more than 2 years, disenrolled in August 1994. In September 1994 Medicare, through the fee-for-service program, paid $46,000 for a cardiac valve procedure without a cardiac catheter and in October 1994 paid $12,000 for a major joint and reattachment procedure of the lower extremity. Instead of paying the managed care plan capitation payments of about $1,000, Medicare paid at least $58,000 in the 2 months following disenrollment. This beneficiary then reenrolled into the same HMO in April 1995 and is currently still enrolled in a managed care plan.

- A beneficiary, enrolled for the 6 years ending February 1996, was admitted to a hospital within 15 days of disenrollment. Medicare fee-for-service then paid the hospital $216,000 for a needed medical service (a tracheostomy except for face, mouth, and neck diagnosis). The capitation for the month following this disenrollment would have been about $600.

* Hospital Cost	$ 216,000
* Capitation	$ 600
* Avoided	$ 215,400

- A beneficiary, enrolled 6 months in a risk plan, disenrolled in July 1996. Six weeks after disenrolling, Medicare paid $30,000 for a major cardiovascular procedure. The beneficiary then reenrolled in the same HMO within 30 days of being discharged.

- A beneficiary, who had been enrolled for 17 months in an HMO, disenrolled and was admitted into an inpatient hospital within 2 months of disenrollment. Medicare fee-for-service paid the hospital $148,000 for a medical service (a tracheostomy except for face, mouth, and neck diagnosis). The capitation for the 3 months following disenrollment would have been about $1,000.

* Hospital Cost	$ 148,000
* Capitation	$ 1,000
* Avoided	$ 147,000

- One beneficiary disenrolled from an HMO after being enrolled for the 10 months ending August 1995. Medicare subsequently paid $26,000 under fee-for-service for nine services furnished to this beneficiary in an inpatient psychiatric hospital. This beneficiary reenrolled in the same HMO for the month of January 1996. After disenrolling again at the end of January, Medicare paid $20,000 for an additional 12 services to an inpatient psychiatric hospital and $8,000 for 2 other inpatient claims during February through June 1996.

- A beneficiary, enrolled in an HMO from August 1990 through February 1995, was admitted into the hospital as a fee-for-service patient within 10 days of disenrollment. Medicare paid the hospital $145,000 for a medical procedure (a tracheostomy except for face, mouth, and neck diagnosis). The capitation for March 1995 would have been approximately $300.

* Hospital Cost	$145,000
* Capitation	$ 300
* Avoided	$144,700

Types of Inpatient Services

As the above examples indicate, there is some commonality as to what type of medical procedures appear to be more susceptible to being performed subsequent to a disenrollment action. For each of the claims identified in our review, we analyzed both the diagnosis related group (DRG) and the major diagnostic category (MDC) where the DRG was classified. We noted the five most frequent DRGs were:

- ✔ 430 - Psychoses
- ✔ 209 - Major Joint and Limb Reattachment Procedure of the Lower Extremity
- ✔ 483 - Tracheostomy Except for Face, Mouth, and Neck Diagnosis
- ✔ 462 - Rehabilitation
- ✔ 127 - Heart Failure and Shock

We also found the most frequent major diagnostic categories were:

- ✔ Circulatory Systems
- ✔ Respiratory Systems
- ✔ Musculoskelative System

Attachment E contains two charts showing additional data on the top three MDCs and the top five DRGs of total Medicare payments.

The following five DRGs represented the highest Medicare fee-for-service payment per discharge and had total payments of $1,000,000 or more within 3 months after disenrollment.

		1 Month		3 Months	
DRG	DRG Name	Total All Services	Average Per Service	Total All Services	Average Per Service
483	Tracheostomy (except for face, mouth, and neck diagnosis)	$4,300,000	$83,000	$8,900,000	$80,000
104	Cardiac Valve Procedures (with a cardiac catheter)	1,400,000	38,000	2,600,00	37,000
108	Other Cardiothoracic Procedures	600,000	33,000	1,000,000	32,000
105	Cardiac Valve Procedures (without a cardiac catheter)	1,000,000	31,000	2,600,000	31,000
106	Coronary Bypass (with cardiac catheter)	2,600,000	30,000	6,000,000	27,000

As can be seen, DRG 483 appears to have been a highly costly fee for service procedure performed after an HMO disenrollment. We are continuing our work to further evaluate this phenomena and will share these results with HCFA when our study is completed.

CONCLUSION AND RECOMMENDATION

Based on our review of beneficiaries who disenrolled from six risk plans during 1991 through 1996, we found that Medicare paid for inpatient hospital services amounting to $224 million in fee-for-service payments within 3 months of these beneficiaries disenrollment from the HMOs. Had these beneficiaries not disenrolled, Medicare would have paid the HMOs $20 million in monthly capitation payments. Had the beneficiaries remained in the HMOs, Medicare would have saved $204 million in expenditures. Included in the Medicare FFS payments were $41 million for beneficiaries who disenrolled, had FFS procedures performed, and then reenrolled into another or the same managed care plan.

Based on our analyses, it appeared that risk plans could avoid significant payments for medical services if sicker beneficiaries or those needing expensive services/treatment disenrolled from the HMO and received the services under FFS. This practice has been

identified in other studies such as the New England Journal of Medicine Article *"The Medicare - HMO Revolving Door--The Healthy Go In and the Sick Go Out."*[2]

As we proceed with further analysis of this issue and specific audit/investigative work at some of the HMOs, we believe the technique we used to analyze the relationship of enrollment/disenrollment actions by specific risk plans could be used by HCFA as part of their evaluation of HMOs. We therefore recommended that HCFA monitor HMO performance by reviewing patients' health status both before and after disenrollment as a part of its CPMS. Specific FFS procedures rendered after disenrollment should be traced to HMO medical records to determine if the beneficiaries ailments were known to the HMO but not adequately/timely treated. By examining FFS inpatient and other medical services provided after disenrollment, HCFA could improve on their quality assurance assessments of HMOs, identify potential cases for referral for investigation and help ensure that HMOs do not manipulate the system by only enrolling and keeping enrolled healthy beneficiaries.

THE FUTURE

This study reviewed only inpatient services performed after disenrollment. Our review did not include the services provided to beneficiaries while enrolled at the six risk plans, nor did it include services provided by home health agencies, skilled nursing facilities, outpatient services, or Medicare Part B services subsequent to the disenrollment actions. As we continue our review of these other medical services, we welcome HCFA's comments on our work completed to date and our future plans.

HCFA COMMENTS

HCFA agreed that *...there was a problem with disenrollment just prior to receiving expensive inpatient services...an informed explanation is needed of why this situation occurs.* A study of disenrollment issues funded by HCFA produced similar results to those of the OIG. HCFA further stated OIG findings *...raised important issues regarding quality of care in managed care and certainly suggest the need for further investigations and careful monitoring of the managed care environment.* The OIG report raised issues that *...HCFA needs to consider with the implementation of the Medicare+Choice program* (managed care provisions enacted by the BBA). HCFA also believes the BBA will alleviate some of the problems.

With respect to the OIG recommendation, HCFA is in the early planning stages of a study which will examine the reasons beneficiaries disenroll prior to a fee-for-service hospitalization. Additionally, HCFA is developing several disenrollment measures, including

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[2]"The Medical - HMO Revolving Door--The Health Go In and the Sick Go Out," Robert O. Morgan, Ph.D.; Beth A. Virnig, Ph.D., M.P.H.; Carolee A. DeVito, Ph.D., M.P.H.; and Nancy A. Persiby, M.P.H. (New England Journal of Medicine, Vol. 337, No. 3, pp. 169 - 175)

a disenrollment survey and a system *that will examine trends in disenrollment by health status.*

HCFA also commented on several technical issues pertaining to the need to more fully understand why beneficiaries disenrolled and whether or not the HMOs and related physicians had a negative influence on the beneficiaries which caused them to disenroll. We agree with HCFA's comments and are involved in other reviews to address these questions. The complete text of HCFA's response is presented as Attachment F to this report.

OIG RESPONSE

In addition to its studies and other efforts, we believe HCFA should include an assessment of patients' health status both before and after disenrollment as a part of its monitoring system. In further audit/investigative work, we intend to address the technical issues raised by HCFA.

We look forward to working with HCFA to obtain a further understanding of the disenrollment issues as the managed care environment evolves further.

ENROLLMENTS AND DISENROLLMENTS

The chart below shows the number of enrollments for every beneficiary who left the risk plan completely or to fee-for-service (FFS).

Comparison of Enrollments to Disenrollments					
HMO	**New Enrollments**	**Total Disenrollments**	**Enrolled Per Disenrolled ❶**	**Disenrolled to FFS**	**Enrolled Per Disenrolled to FFS ❷**
HMO 1	340,000	158,000	2.2	45,100	7.5
HMO 2	255,000	190,000	1.3	57,100	4.5
HMO 3	280,000	237,000	1.2	105,600	2.7
HMO 4	25,000	22,000	1.1	8,800	2.8
HMO 5	69,000	15,000	4.6	6,600	10.5
HMO 6	84,000	9,000	9.3	4,700	17.9
Six Plans	1,053,000	631,000	1.7	227,900 ❸	4.6
All Risk Plans	4,683,000	1,840,000	2.5		

❶ **Enrolled per Disenrolled equals:** $\frac{\text{New Enrollments}}{\text{Total Disenrollments}}$

❷ **Enrolled per Disenrolled to FFS equals:** $\frac{\text{New Enrollments}}{\text{Disenrolled to FFS}}$

❸ **See Attachment A, Page 2 of 2 for an additional detail on these disenrollments, by HMO.**

DISENROLLMENTS TO FEE-FOR-SERVICE

As shown in the chart on the previous page, there were 228,000 disenrollments to fee-for-service during 1991 through 1996 at the six plans we reviewed. The chart below reflects the total number of disenrollments from HMOs to Medicare fee-for-service by year.

Disenrollments to Medicare Fee-For-Service by Year							
HMO/ Year	**1991**	**1992**	**1993**	**1994**	**1995**	**1996 - ❶**	**Total**
HMO 1	5,700	6,900	8,600	8,900	9,000	6,000	45,100
HMO 2	14,400	9,600	9,700	❷ 9,500	❷ 8,300	5,600	57,100
HMO 3	20,600	21,100	21,400	❷ 16,700	❷ 15,300	10,500	105,600
HMO 4	1,300	1,500	1,500	1,200	2,500	800	8,800
HMO 5	800	900	1,000	1,100	1,300	1,500	6,600
HMO 6	0	0	100	900	1,600	2,100	4,700
Total	42,800	40,000	42,300	38,300	38,000	26,500	227,900

❶ - 1996 data are from January through approximately August 1996.

❷ - Although the number of disenrollments to Medicare fee-for-service decreased significantly, the number of transfers into another plan also increased significantly for these two plans.

Attachment B

Amount Paid to Inpatient Hospitals Within 3 Months of Disenrolling (in thousands)							
HMO/ Year	**1991**	**1992**	**1993**	**1994**	**1995**	**1996 - ❶**	**Total**
HMO 1	$4,248	$5,630	$7,881	$8,859	$10,454	$8,047	$45,119
HMO 2	11,877	10,080	9,580	11,970	12,305	7,777	63,589
HMO 3	14,950	20,020	21,101	17,764	17,684	11,010	102,529
HMO 4	531	757	911	562	1,410	365	4,536
HMO 5	266	483	534	629	1,077	1,238	4,227
HMO 6	0	0	77	556	1,484	2,562	4,679
Total	$31,872	$36,970	$40,084	$40,340	$44,414	$30,999	$224,679

❶ - 1996 data are from January through approximately August 1996.

Attachment C

MEDICARE CAPITATIONS NOT MADE

The charts below show an estimation of the capitation payments that were not made within 1 and 3 months of disenrolling.

Medicare Capitation Payment Not Made Within 1 Month of Disenrollment (in thousands)							
HMO/ Year	**1991**	**1992**	**1993**	**1994**	**1995**	**1996 - ❶**	**Total**
HMO 1	$79	$99	$151	$172	$194	$144	$839
HMO 2	230	184	188	231	212	164	1,209
HMO 3	304	367	427	371	367	247	2,083
HMO 4	12	10	17	10	26	7	82
HMO 5	4	8	14	17	16	21	80
HMO 6	0	0	0	13	25	53	91
Total	$629	$668	$797	$814	$840	$636	$4,384

Medicare Capitation Payment Not Made Within 3 Months of Disenrollment (in thousands)							
HMO/ Year	**1991**	**1992**	**1993**	**1994**	**1995**	**1996 - ❶**	**Total**
HMO 1	$392	$469	$699	$738	$810	$601	$3,709
HMO 2	1,163	853	939	1,010	1,000	682	5,647
HMO 3	1,486	1,722	1,982	1,704	1,667	1,158	9,719
HMO 4	41	67	91	65	144	45	453
HMO 5	34	48	52	67	106	130	437
HMO 6	0	0	2	72	157	231	462
Total	$3,116	$3,159	$3,765	$3,656	$3,884	$2,847	$20,427

Attachment D

MEDICARE PAYMENTS TO INPATIENT HOSPITALS IN LIEU OF CAPITATION PAYMENTS

The charts below show the net effect of inpatient expenditures less capitation payments the plan would have received (within 3 months of disenrollment) for each of the six plans.

Medicare Payments to Inpatient Hospitals in Lieu of Capitation Payments Within 1 Month of Disenrollment (in thousands)							
HMO/ Year	1991	1992	1993	1994	1995	1996 - ❶	Total
HMO 1	$1,531	$2,285	$3,200	$3,710	$4,458	$3,576	$18,760
HMO 2	3,955	4,017	3,250	4,778	4,317	3,362	23,679
HMO 3	5,632	7,540	7,752	6,606	6,980	4,091	38,601
HMO 4	221	201	318	120	540	90	1,490
HMO 5	75	142	215	223	272	292	1,219
HMO 6	0	0	0	220	398	993	1,611
Total	$11,414	$14,185	$14,735	$15,657	$16,965	$12,404	$85,360

Medicare Payments to Inpatient Hospitals in Lieu of Capitation Payments Within 3 Months of Disenrollment (in thousands)							
HMO/ Year	1991	1992	1993	1994	1995	1996 - ❶	Total
HMO 1	$3,856	$5,161	$7,182	$8,121	$9,644	$7,446	$41,410
HMO 2	10,714	9,227	8,641	10,960	11,305	7,095	57,942
HMO 3	13,464	18,298	19,119	16,060	16,017	9,852	92,810
HMO 4	490	690	820	497	1,266	320	4,083
HMO 5	232	435	482	562	971	1,108	3,790
HMO 6	0	0	75	484	1,327	2,331	4,217
Total	$28,756	$33,811	$36,319	$36,684	$40,530	$28,152	$204,252

❶ - 1996 data are from January through approximately August 1996.

Attachment E

MEDICARE PAYMENTS ACCORDING TO MAJOR DIAGNOSTIC CATEGORIES AND DIAGNOSIS RELATED GROUPS

This table illustrates the top three MDCs of total Medicare payments:

Medicare Payments According to MDC (in millions)		
MDC	**1Month**	**3 Months**
Circulatory Systems	$21	$54
Respiratory Systems	10	28
Musculoskelative System	9	25
Total Top Three MDCs	40	106
Total All Inpatient Services	$89	$224
Percentage Top Three MDCs	45%	47%

We examined DRGs on the claims paid by Medicare, regardless of the MDC. The table below shows the top five DRGs of total Medicare payments:

Medicare Payments According to DRG (in millions)		
DRG	1 Month	3 Months
430 - Psychoses	$6.4	$13.5
209 - Major Joint & Limb Reattachment ...	3.5	10.9
483 - Tracheostomy Except for Face, Mouth..	4.3	8.9
462 - Rehabilitation ...	4.6	8.2
127 - Heart Failure & Shock ...	2.7	7.4
Total 5 DRGs	$21	$49
Total All DRGs	$89	$224
Percentage Top 5 DRGs	23%	22%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

DATE: FEB 2 6 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min Deparle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care"-- A-07-98-01256

The OIG's draft report analyzes the cost of inpatient care given through fee-for-service (FFS) Medicare to beneficiaries previously enrolled in a Medicare Managed Care plan from 1991 to 1996. The report raises interesting and important issues with regard to the costs and quality of care which HCFA needs to consider with the implementation of the Medicare+Choice (M+C) program. The study focuses on identifying and describing the potentially avoidable payments made by HCFA for services received in the FFS setting by beneficiaries who disenroll from managed care organizations.

It should be noted that the study is subject to a number of limitations. For example, the analysis includes only six plans - three of which appear to drive the study results. The behavior of these three plans is not necessarily representative of the industry. In addition, costs for the plans are summed over the course of 6 years.

The report emphasizes that the Medicare program paid hospitals $224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment and continues by stating that Medicare would have paid $20 million in capitation payments to these six firms had beneficiaries not disenrolled resulting in a difference of $204 million. The following questions also arise:

1) How do we know the type of care that would have been received had the beneficiary stayed with the HMO?

2) How were the plans selected for analysis. In other words, how does the OIG define "judgementally selected?"

3) Was any medical review done for any of the cases cited in order to further assess the possible reasons for the care received after disenrollment?

4) Were any of the beneficiaries personally interviewed or did any of the plans collect data on the reasons for disenrollment?

5) What part does beneficiary choice play in the disenrollment from an HMO to a fee-for-service plan and subsequent re-enrollment with the HMO?

6) Were the hospitals that provided the inpatient services part of the network of the plan from which the beneficiary was disenrolling?

The study findings imply that managed care plans may be 'gaming' the system, intending to avert their own costs at a high cost to the Medicare program; that access to care may be a problem because beneficiaries seek care from alternative providers in the FFS system, and that sicker patients may be leaving managed care. There are three distinct parties with incentives to encourage disenrollment from managed care to return to FFS. They include:

- **The managed care plan.** The incentive to have a beneficiary join FFS allows the plan to avoid paying for expensive inpatient services. OIG has focused on the managed care plans in their report.

- **The beneficiary.** Given the 30-day disenrollment rules, the beneficiary has an incentive to switch to FFS if there is a reason to select a provider who is not in the managed care network. For example, if the Mayo Clinic is the premier hospital for a specific service but is not in the managed care network or on the list of providers, a beneficiary could disenroll to access care from Mayo Clinic and then re-enroll in the managed care plan after the service has been delivered.

- **The provider.** The physician, for clinical reasons, may recommend that the beneficiary disenroll to seek services from out-of-network providers. During the study period there were no constraints or regulations against voluntary disenrollment. It is also possible that financial incentives may lead providers to refer enrollees to out-of-network providers. The provider may receive different payment levels for the same service depending on who is paying the bill, the managed care plan or Medicare FFS. In many cases, the provider receives a discounted payment through managed care so they have an incentive to encourage patients to temporarily re-enroll in FFS.

The study findings raise important issues regarding quality of care in managed care and certainly suggest the need for further investigation and careful monitoring of the managed care environment. HCFA is in the process of conducting further analysis of disenrollment and developing monitoring tools to assess plan performance.

- A recent collaborative study between HCFA and the University of Minnesota School of Public Health is consistent with the findings in the OIG report. It compared the utilization experience and health status of HMO disenrollees for six months post disenrollment during 1994 with a comparable continuously enrolled group of FFS beneficiaries. Study findings indicated that HMO disenrollees appeared to be sicker than the continuing FFS beneficiaries. HMO disenrollees were significantly more likely to have had at least one procedure or received at least one diagnosis during the six month post-disenrollment period.

- HCFA is developing several disenrollment measures which will become a part of our performance measurement system. This will involve a disenrollment survey to provide more information about why beneficiaries leave plans.

- HCFA is designing an M+C evaluation system that among other analyses will examine trends in disenrollment by health status.

Certain M+C program policies will protect against some of the concerns raised in this study. These policies include the following:

- **Risk Adjustment.** The implementation of a risk adjusted payment system will pay M+C organizations for caring for sicker patients, lessening the incentive to direct patients to FFS for treatment of the expensive conditions.

- **Patient Lock-in.** The Balanced Budget Act of 1997 also provided for a lock-in to a M+C plan that does not currently exist. This lock-in is phased in beginning in CY 2002. Once beneficiaries must remain with their choice of M+C organization, the dynamics of disenrollment will change. The collection of encounter data will support examination of potential changes in utilization patterns. These issues will be monitored in the evaluation of the M+C program.

- **Informed Consumers.** The M+C program will provide an extensive range of information about M+C organizations for consumer use. This will provide

beneficiaries with information so they can make informed decisions about which M+C organization will best serve their needs. We expect this will reduce the rate of disenrollment from plans.

In summary, we agree with OIG that there is a problem with disenrollment just prior to receiving expensive inpatient services. An informed explanation is needed of why this situation occurs and the extent to which it can be expected to reoccur in the M+C program. We want to work with the OIG to address the limitations that we have identified in the methodology used in this review so that the future audits and investigative work the OIG has planned will be more useful to HCFA in evaluating HMO performance.

We believe that the risk adjusted payment mechanism and lock-in provisions of the BBA will alleviate some of the problem by making sure that M+C organizations are paid for sicker enrollees and that beneficiaries remain with their M+C organization until the next election. However, the lock-in will also require our focus on utilization patterns of the different M+C organizations, as well as disenrollment trends to ensure that beneficiaries have access to the services to which they are entitled. With respect to the OIG's recommendation that HCFA consider including an evaluation of the services provided to beneficiaries, HCFA is now in the early planning stages of a study which will examine the reasons that beneficiaries disenroll prior to a FFS hospitalization. This study will employ personal interviews of the beneficiaries who have disenrolled and then been hospitalized in the FFS system. This study will also examine the frequency and distribution of these events on a national basis and the extent to which these beneficiaries reenroll in the same or a different managed care organization.