United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce

November 1985

ARIZONA MEDICAID

Nondisclosure of Ownership Information by Health Plans

GAO/HRD-86-10

About Our New Look . . .

This GAO report was produced using a new design and printing process to help you get the information you need more easily.

GAO will phase in this new design during 1985. As we do so, we welcome any comments you wish to share with us.

GAO

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

Human Resources Division
B-220864

November 22, 1985

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This is in response to your Committee's request for information on compliance with federal requirements for disclosure of ownership information by prepaid health plans participating in Arizona's Health Care Cost Containment System (AHCCCS). Our findings are summarized in this letter and detailed in appendix I.

AHCCCS, which began operations in October 1982, is a 3-year Medicaid demonstration project approved by the Health Care Financing Administration (HCFA). Before AHCCCS, Arizona was the only state without a Medicaid program. HCFA approved an extension of the program through July 1986.

Under authority of section 1115(a) of the Social Security Act, HCFA granted waivers to Arizona enabling AHCCCS to operate differently from conventional Medicaid programs. The goal of the demonstration project is to develop and test certain innovations designed to constrain health care costs, including contracting with a number of prepaid health plans, selected through a competitive bidding procedure, to provide services to Medicaid beneficiaries for a set rate per beneficiary.

In 1977, the Congress enacted Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, to prevent and detect fraud and abuse in government health care programs. Specifically, sections 1124 and 1902(a)(38) of the Social Security Act were added to strengthen disclosure requirements and provide an additional audit tool for project managers and auditors to help control program payments involving related organizations.

These statutory provisions were enacted after reviews of a prior Medicaid experiment with prepaid health plans in California disclosed that nonprofit, tax-exempt health plans were subcontracting with related for-profit providers, enabling funds to be diverted from the provision of needed health care.

We found that many AHCCCS health plans have not complied with federal disclosure requirements intended to determine the appropriateness of ownership and control arrangements and related-party transactions. This raises questions about (1) the availability of federal funding for health plan operations during the periods of noncompliance and (2) the continued participation in AHCCCS of health plans that have not complied with disclosure requirements.

Ownership and Control Information

HCFA regulations state that a Medicaid agency must require health care providers to identify each person with an ownership or control interest in the health plan, including officers or directors. Subcontractors in which the health plan directly or indirectly has a 5-percent or more ownership interest must also be identified. HCFA regulations also specify that if a provider fails to disclose the required ownership and control information, (1) provider contracts should not be approved and existing contracts should be terminated and (2) federal financial participation is not available for provider payments.

AHCCCS and HCFA have not assured compliance with these disclosure requirements before awarding and renewing AHCCCS health plan contracts. Of the 19 health plans awarded AHCCCS contracts in the second year (1983-84), 3 did not disclose direct or indirect ownership, and 1 did not disclose officers or directors. Furthermore, AHCCCS renewed 18 contracts for the third program year without assuring compliance with disclosure requirements.

We noted ownership and control arrangements in participating AHCCCS plans similar to those identified in the California experiment previously mentioned. For example, one AHCCCS health plan that did not disclose ownership and control arrangements, Health Care Providers of Arizona, Inc., was tied to 10 other firms in which its owners had a controlling interest. AHCCCS terminated its contract with Health Care Providers in April 1985 because the plan could not meet its outstanding liabilities.

On June 12, 1985, we briefed AHCCCS officials on the results of our review. In a June 21, 1985, letter, the AHCCCS Director submitted additional information on second-year health plans that he believed demonstrated "substantial" compliance. We do not believe the additional information provided for these four plans demonstrates compliance with the disclosure requirements (see app. VI).

Related-Party Transactions

Related-party transactions within the corporate structures described above can enable health plans to divert program funds from their intended purpose—the provision of health care. They can lead to unnecessary administrative costs and excessive profits. Underservicing of the Medicaid population may occur if program payments are used to pay unnecessary administrative costs or excessive profits to related parties rather than to provide medical care services.

HCFA regulations require that agreements between a Medicaid agency and a provider include a provision whereby the provider agrees to disclose information on certain related-party transactions to the state or HCFA upon request. Providers must disclose (1) ownership of any subcontractor with annual transactions exceeding $25,000 and (2) significant transactions with any wholly owned supplier or any subcontractor during the 5 years preceding the request. HCFA regulations require that federal financial participation generally be denied for the period in which a provider was delinquent in filing such information.

None of the 15 plans required to submit disclosure statements on related-party transactions for the first year (1982-83) submitted them on time. As of June 21, 1985, only four first-year plans had submitted statements. Seven of the 18 plans required to submit statements by December 30, 1984, for second-year operations (1983-84) had not submitted them as of June 21, 1985. Eight of the plans that did submit statements did not submit them on time. Yet federal financial participation has not been denied in cases where health plans have not promptly disclosed these transactions.

Furthermore, AHCCCS has not reviewed the completeness of the disclosure statements submitted. In an August 1984 report covering AHCCCS' first 18 months of operations, Peat Marwick Mitchell and Company, under contract with AHCCCS, identified $66.6 million in related-party transactions. We determined that $14.6 million involved transactions required to be disclosed. Our review shows that the AHCCCS plans did not disclose 64 percent of these transactions.

For example, one AHCCCS health plan, Gila Medical Services, did not file a disclosure statement for the first fiscal year and did not report certain related-party transactions requiring disclosure on its second-year disclosure statement.

Recommendations

We recommend that the Secretary of Health and Human Services (HHS) direct the Administrator of HCFA to review AHCCCS plan contract proposals and renewal submissions and determine the extent to which federal financial participation should not be available for plans that did not comply with disclosure laws for ownership and control information and/or related-party transactions. Our other recommendations are for AHCCCS and HCFA to institute procedures to ensure that AHCCCS plans comply with these disclosure requirements in the future.

Agency Comments and Our Evaluation

In commenting on our draft report, both HHS (see app. VII) and the Governor of Arizona (see app. VIII) agreed that many AHCCCS health plans had technically not complied with federal disclosure requirements for ownership and control arrangements and related-party transactions. They said that actions have been or will be taken to ensure that disclosure requirements are followed for future AHCCCS health plan contracts.

HHS disagreed with our recommendations that it retrospectively review ownership and control and related-party transaction disclosures by AHCCCS health plans to determine the availability of federal financial participation. HHS concluded that because the state's reinvestigation of the cases showed "substantial" compliance with the disclosure requirements, further investigation was not warranted. We believe HHS' conclusion is premature.

The Governor said the state's major concern with our report is that it said little about the many positive steps Arizona has taken since assuming full administrative responsibility for the program in March 1984. Although we agree that the state has taken aggressive action to improve program monitoring since it assumed administrative responsibility for the program, those actions were not adequate to assure compliance with the disclosure requirements in the program's second and third year. In addition, as discussed on pages 12 and 14, we do not agree that the state's reinvestigation showed the AHCCCS plans to be in compliance with the disclosure requirements. Furthermore, the 1985 annual report prepared by the AHCCCS Fraud Investigation and Prosecution Unit of the Arizona Attorney General's office notes that the unit is pursuing allegations of fraud in the operation of three AHCCCS health plans. The report states that investigations are primarily focused on patterns of criminal activity involving kickbacks, embezzlement, false claims to the government, willful concealment from the government, and illegal control of an enterprise (racketeering). According to the assistant attorney general in charge of the fraud unit, if the state can prove that a health plan failed

to file, or filed a false, state-required quarterly financial statement or federal- or state-required report on related-party transactions with intent to defraud, it can obtain a felony conviction.

Accordingly, we continue to believe that HCFA should investigate the extent of past noncompliance and the reasons for that noncompliance. Determinations on the availability of federal financial participation for services provided by nondisclosing plans should, in our opinion, be made only after completion of the reviews by HCFA and the fraud investigations by the Attorney General's office.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its issue date. At that time we will send copies to HHS, Arizona, and other interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel
Director

Contents

Abbreviations

AHCCCS	Arizona Health Care Cost Containment System
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

Noncompliance With Disclosure Requirements

Background

Title XIX of the Social Security Act authorizes federal participation in the costs of state medical assistance (Medicaid)[1] programs that conform to the act's provisions. The federal government pays between 50 and 78 percent of the costs of providing medical services under Medicaid, depending on a state's per capita income.

The Social Security Act requires a state wishing to participate in Medicaid to submit to the Secretary of Health and Human Services (HHS) a plan for medical assistance (state plan) that meets the conditions specified in the act and in applicable regulations. The Secretary must approve any state plan that meets those conditions.

The Health Care Financing Administration (HCFA) administers Medicaid at the federal level. HCFA develops program policies, sets standards, and assures compliance with federal legislation and regulations for the program.

Section 1115(a) of the Social Security Act allows the Secretary of HHS to waive compliance with state plan requirements so that state Medicaid agencies can carry out significant projects demonstrating new ideas for health care delivery. All requirements of the Social Security Act and the Code of Federal Regulations that pertain to the Medicaid program apply to a project approved under section 1115(a), unless they are specifically waived by the Secretary.

Arizona Health Care Cost Containment System

The Arizona Health Care Cost Containment System (AHCCCS), which began operations in October 1982, is a 3-year Medicaid demonstration project approved by HCFA.[2] Before AHCCCS, Arizona was the only state without a Medicaid program. HCFA approved an extension of the program through July 1986.

Under section 1115(a), HCFA granted waivers to Arizona enabling AHCCCS to operate differently from conventional Medicaid programs. The goal of the demonstration project is to develop and test certain innovations designed to constrain health care costs. The innovations include using:

[1]Medicaid provides medical services to persons unable to pay for such care.

[2]Under AHCCCS, Arizona is required to provide, through participating health plans, health care to federally mandated eligible groups (e.g., recipients of the Aid to Families with Dependent Children and Supplemental Security Income Programs). The health plans must provide all the federally mandated Medicaid services except for skilled nursing facility care, home health care, nurse mid-wife services, and family planning services.

- competitive bidding to select health plans,
- prepaid capitated financing[3] of health plans as an alternative to fee-for-service payments,
- primary care physicians as "gatekeepers" to manage and control beneficiaries' access to services,
- restrictions on beneficiaries' freedom of choice in selecting providers, and
- copayments to discourage excessive use of services.

Through September 30, 1985, AHCCCS is projected to cost the federal government $155.1 million. About 91,000 federally eligible beneficiaries were enrolled in the system as of March 1985.

Under AHCCCS, the state contracts with prepaid health plans to deliver health care for a fixed monthly premium for each enrolled beneficiary. The participating prepaid health plans, as well as premium prices, were determined in bidding procedures in the first and second year of the demonstration project. Contracts for most prepaid health plans were renewed for the project's third year.

Financial Disclosure Requirements

In 1977, the Congress enacted Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, to prevent and detect fraud and abuse in government health care programs. Specifically, sections 1124 and 1902(a)(38) of the Social Security Act were added to strengthen disclosure requirements and provide an additional audit tool for project managers and auditors to help control program payments involving related organizations.

These statutory provisions were enacted after our reviews[4] of a prior Medicaid experiment with prepaid health plans in California disclosed that nonprofit, tax-exempt health plans were subcontracting with related for-profit providers, enabling funds to be diverted from the provision of needed health care. In that program, many of the prepaid health plans were nonprofit corporations that contracted for needed services with for-profit corporations that were created by, or involved

[3]This involves paying a set premium in advance to a health care provider, usually a health maintenance organization or similar organization, for comprehensive medical care.

[4]Better Controls Needed for Health Maintenance Organizations Under Medicaid in California (B-164031(3), Sept. 10, 1974); Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program (MWD-76-15, Aug. 29, 1975); and Relationships Between Nonprofit Prepaid Health Plans With California Medicaid Contacts and For-Profit Entities Affiliated With Them (HRD-77-4, Nov. 1, 1976).

ownership interests on the part of directors and/or officers of the nonprofit entities.

Related-party transactions within these corporate structures can enable health plans to divert capitation funds from their intended purpose—the provision of health care. They can lead to unnecessary administrative costs and excessive profits. Underservicing of the Medicaid population may occur if capitation payments are used to pay unnecessary administrative costs or excessive profits to related parties rather than to provide medical care services. For example, we reported in 1976 that a California prepaid health plan retained 5 percent of the Medicaid funds for internal expenses, while the remainder flowed to affiliated for-profit firms. One firm, which provided administrative and management services to the plan, derived about 41 percent of its revenues from the plan and realized an 18.5-percent profit on its revenues.

Arizona did not request and HCFA did not grant waivers of these disclosure requirements for AHCCCS.

Scope and Methodology

To determine AHCCCS health plans' compliance with federal disclosure requirements, we:

1. Reviewed applicable laws, regulations, and procedures to determine whether AHCCCS plans were subject to financial disclosure requirements and to identify possible penalties for not complying with such requirements.

2. Compared related-party transactions identified in an August 1984 financial and compliance review of AHCCCS plans by Peat, Marwick, Mitchell and Company to transactions disclosed to AHCCCS by the plans to determine if they met the requirements for full and complete disclosure.

3. Reviewed AHCCCS files for second-year (October 1983-September 1984) and third-year (October 1984-September 1985) contracts to determine whether ownership and control arrangements were disclosed before contract award.[5]

[5]First-year contracts were not available at AHCCCS offices.

4. Discussed AHCCCS plans' compliance with disclosure requirements with AHCCCS and HCFA officials to determine why the requirements had not been enforced.

We did not review the effect of ownership and control arrangements or related-party transactions on plan operations.

Our review was performed in accordance with generally accepted government audit standards.

Noncompliance With Disclosure Requirements

HCFA and AHCCCS have not effectively assured compliance with federal requirements for disclosure of ownership and control arrangements and related-party transactions.

Ownership and Control

HCFA regulations state that a Medicaid agency must require providers to identify each person with an ownership or control interest in the health plan, including officers and directors. Subcontractors in which the health plan directly or indirectly has a 5-percent or more ownership interest must also be identified (42 C.F.R. 455.104).

HCFA regulations specify that:

- Medicaid agencies must require each disclosing entity[6] to disclose specified ownership and control information before entering into a contract unless such information has been supplied to HHS within the preceding 12 months.
- Provider agreements or contracts shall not be approved and existing contracts must be terminated if the provider fails to disclose the required ownership or control information.
- Federal financial participation is not available for payments made to a provider that fails to disclose required ownership or control information.

[6]"Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. Because AHCCCS health plans are not individuals and do not meet the definition of "group of practitioners," they are subject to the disclosure requirements.

AHCCCS and HCFA have not assured compliance with the disclosure requirements before awarding and renewing AHCCCS health plan contracts. Furthermore, AHCCCS neither reviewed the information submitted by AHCCCS plans nor terminated contracts with plans that have not made required disclosure. For example, AHCCCS requested bidding health plans to include information on ownership and control arrangements in their second-year (1983-84) contract proposals. AHCCCS awarded contracts to three health plans that did not disclose direct or indirect ownership and one health plan that did not disclose officers or directors. (See app. IV.) HCFA, in turn, approved each of the contracts because HCFA's contract review procedures do not include a determination of compliance with the ownership and control disclosure requirements. Similarly, AHCCCS renewed 18 third-year contracts without assuring compliance with disclosure requirements.

We noted ownership and control arrangements in participating AHCCCS plans similar to those identified in the California experiment previously mentioned. For example, one AHCCCS health plan that did not disclose ownership and control arrangements, Health Care Providers of Arizona, Inc., was tied to 10 other firms in which its owners had a controlling interest. (See app. II.) Two persons with a combined interest of two-thirds ownership in the plan wholly owned nine of these organizations, seven of which received payments from the plan for various medical services. AHCCCS terminated its contract with Health Care Providers in April 1985 because the plan could not meet its outstanding liabilities.

On June 12, 1985, we briefed AHCCCS officials on the results of our review. In a June 21, 1985, letter, the AHCCCS Director submitted additional information that he believed showed that all second-year AHCCCS plans were in "substantial" compliance with the spirit and letter of disclosure regulations. We agreed with him on one plan and revised this report to reflect its compliance with the disclosure requirements. However, we do not believe the additional information provided on four other plans demonstrates compliance with the disclosure requirements. Appendix VI contains an analysis of the information AHCCCS submitted on the four plans.

Related-Party Transactions

HCFA regulations require that agreements entered into between a Medicaid agency and a provider must include a provision whereby the provider agrees to disclose information on certain related-party transactions to the state agency or the Secretary of HHS upon request. Generally, such agreements must require providers to disclose, upon

request, (1) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 in the past year and (2) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 years preceding the request (42 C.F.R. 455.105).

Under HCFA regulations, federal financial participation is not available to providers who fail to comply with a request for disclosure of related-party transactions within 35 days. Federal financial participation shall be denied from the day following the date the information was due to the day before the date the information was supplied (42 C.F.R. 455.105(c)). The Secretary may allow more time for the submission of information before terminating a provider agreement or withholding federal financial participation. Such extensions are to be the exception rather than the rule. The provider bears the burden of persuading the Secretary that the reasons for noncompliance are valid.

In his June 21, 1985, letter, the AHCCCS Director said that the regulations were not violated because no request for disclosure of related-party transactions was made within the contemplation of the regulation. However, in May 1983, Arizona established financial reporting requirements that specifically requested first-year (1982-83) AHCCCS plans to submit the information on related-party transactions required by regulation by December 31, 1983. AHCCCS included instructions for reporting related-party transactions that specifically cited the section 1902(a)(38) requirements.

None of the 15 plans required to submit disclosure statements submitted them on time. As of June 21, 1985, only four plans had submitted statements for first-year operations (October 1982-September 1983). Furthermore, as of that date, 7 of the 18 plans required to submit statements for second-year operations (1983-84) had not submitted them. Eight of the 11 plans that submitted disclosure statements did not submit them on time (by Dec. 31, 1984). (See app. V.) Federal financial participation has not been denied during the periods of noncompliance. Nor has AHCCCS reviewed the completeness of the disclosure statements submitted or the reasonableness of the transactions reported.

In its August 1984 report on AHCCCS plans' first 18 months of operations, Peat Marwick identified about $66.6 million in related-party transactions. We determined that $14.6 million involved transactions requiring disclosure under the regulations. Our review showed that the AHCCCS

plans did not disclose 64 percent of these transactions. Only 4 of the 11 plans that submitted financial disclosure statements disclosed all of the related-party transactions that should have been disclosed.

For example, one AHCCCS health plan, Gila Medical Services, did not file a disclosure statement for the first fiscal year. The plan filed a second-year disclosure statement on June 3, 1985, but did not report certain related-party transactions requiring disclosure. The plan (1) rented the plan's clinic facility from, and provided an interest-free loan to, the plan's vice president and (2) rented a house and computer from the plan's owner and provided him an interest-free loan. Appendix III provides additional details on Gila Medical Service's related-party transactions.

On June 14, 1985, 2 days after we brought the problem to its attention, AHCCCS sent letters to prepaid health plans that did not file statements disclosing related-party transactions for the second year, giving them 35 days to file such information.

In his June 21, 1985, letter, the AHCCCS Director cited the August 1984 Peat Marwick report as an example of AHCCCS' sustained commitment to program integrity. In addition, for four of the seven AHCCCS plans that had not filed annual disclosure statements for second-year operations, AHCCCS provided annual certified audits (three plans) or an accounting firm's report on related-party transactions (one plan) to demonstrate disclosure of such transactions.

Neither the Peat Marwick report nor the other reports AHCCCS provided disclose as much information on related-party transactions as the AHCCCS disclosure forms. Generally the reports contained only the identity of the related party, a description of the transaction, and the amount of the transaction. By contrast, the AHCCCS disclosure form requires plans not only to disclose the above information, but to justify the reasonableness of the transactions and estimate their potential adverse impact on the plan's fiscal soundness.

In summary, we believe that the Peat Marwick report and financial audits of plan operations should be used by AHCCCS, not as an alternative to disclosure of related-party transactions by AHCCCS plans, but as a check on the completeness of such disclosures.

Conclusions

Because many AHCCCS prepaid health plans have not complied with federal requirements for disclosure of ownership and control arrangements and related-party transactions, HCFA and the state do not know whether capitation funds are being appropriately used to provide health care services for Arizona's Medicaid population. HCFA and the state need to enforce disclosure requirements and review the reasonableness of related-party transactions.

Recommendations

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

1. Review AHCCCS plan contract proposals and renewal submissions to determine whether health plans complied with the ownership and control disclosure requirements and determine the extent to which federal financial participation should be recouped for payments made to AHCCCS health plans that did not comply.

2. Obtain from each health plan that did not provide full and complete disclosure of related-party transactions on time an explanation of the reason(s) for nondisclosure and, based on an evaluation of those reasons, determine the extent to which federal financial participation should be recouped for period(s) of nondisclosure.

3. Direct AHCCCS to review reported related-party transactions to ensure that they do not divert capitation payments away from health care.

4. Ensure that each contract between AHCCCS and a provider that does not disclose ownership and control arrangements is terminated.

5. Establish procedures to ensure that HCFA does not approve future Medicaid contracts that are lacking required disclosure of ownership and control arrangements.

Agency Comments and Our Evaluation

In commenting on a draft of our report, both HHS (see app. VII) and the state of Arizona (see app. VIII) agreed with our finding that many AHCCCS health plans had not technically complied with federal disclosure requirements for ownership and control arrangements and related-party transactions. They said that actions have been or will be taken to ensure disclosure requirements are followed concerning future AHCCCS health

plan contracts. HHS disagreed with recommendations that it retrospectively review ownership and control and related-party transaction disclosures by AHCCCS health plans to determine the availability of federal financial participation. HHS concluded that because the state's reinvestigation of the cases showed "substantial" compliance with the disclosure requirements, further investigation was not warranted.

AHCCCS Comments

The Governor of Arizona indicated that AHCCCS did not disagree[7] with our findings that many second- and third-year AHCCCS plans have not complied with federal disclosure requirements intended to determine the appropriateness of ownership and control arrangements and related-party transactions. He said that the state has taken several actions to ensure that health plans make full disclosure in the fourth year (October 1985-September 1986). Specifically,

- the request for proposal addressed the federal disclosure requirements,
- all health plans were required to complete ownership and control and related party transaction forms before receiving a contract,
- the state Attorney General's Office agreed to perform a criminal history check on every owner and executive of an AHCCCS health plan, and
- AHCCCS audit staff have been directed to visit each health plan in the beginning of the new contract year to review related-party transactions.

The Governor expressed concern, however, that too little was said in the report about the many positive steps the state has taken since it assumed full administrative responsibilities for AHCCCS in March 1984. Additionally, he said that our including examples from the California program was particularly troubling in light of the major effort the state has made to avoid the problems that arose in California.

Actions to Prevent Program Abuse

According to AHCCCS, a major shift in the philosophy and operation of the program has occurred since the state's March 1984 takeover of the private contract administrator's responsibilities. AHCCCS said that it has taken a strong stand as a regulator of the program and that significant changes have taken place in the program pursuant to monitoring the fiscal integrity and contractual performance of AHCCCS health plan contractors.

[7]Except as noted in the AHCCCS Director's June 21, 1985, letter, which is discussed in appendix VI.

AHCCCS said that one of the first actions initiated by the state after it assumed administrative control of the program was to award a contract to Peat Marwick to conduct a financial and compliance review of AHCCCS health plans' first 18 months operations. (See p. 13 for a discussion of the Peat Marwick findings regarding related-party transactions.) According to AHCCCS, it provided the state Attorney General's Office a copy of the Peat Marwick report and recommended that the related-party transactions and ownership relationships be examined. AHCCCS said that the Attorney General initiated a comprehensive investigation into certain health plan activities and that the investigation results will soon be made public.

AHCCCS added that operational and structural changes it has made during the past 18 months demonstrate that the current AHCCCS administration has taken aggressive and positive action to ensure that health plan contractors make full and complete disclosure of ownership and control arrangements and related-party transactions. In addition to the previously mentioned actions, AHCCCS said that it

- prepared an audit guide for health plan contractors, including a supplementary schedule of financial data which includes related-party transactions;
- notified health plans that an annual certified audit is required for the third year of operation and that the audit guide must be followed;
- established an Office of Audits and Compliance and increased audit professional staff; and
- established AHCCCS fraud investigation units both within AHCCCS and within the Attorney General's Organized Crime and Racketeering Division.

According to AHCCCS, these actions show that it never intended to use the Peat Marwick report and financial audits of plan operations as an alternative to disclosure of related-party transactions.

We agree that the state has taken aggressive action to improve program monitoring since it assumed administrative responsibility for the program; those actions, however, were not adequate to assure compliance with the disclosure requirements in the program's second and third year. Specifically, although AHCCCS established requirements for disclosure of ownership and control arrangements (see p. 12) and related-party transactions (see p. 13), AHCCCS did not review the completeness of the disclosure statements submitted for the second or third year to determine whether contractors complied with the requirements. Nor did

AHCCCS use the Peat Marwick report to obtain disclosures from health plans identified in that report as not filing required disclosure statements.

Quality of Care

AHCCCS said that quality care is the program's principal objective and that it is sensitive to the threat of provider underservicing in a capitated prepaid environment. According to AHCCCS, to protect against health plans diverting funds from their intended purpose of providing quality medical care, it has taken a multidisciplinary approach to monitor service utilization patterns.

In addition to financial and contract compliance reviews, AHCCCS said it administers beneficiary grievance hearings, is developing medical service utilization reviews, and contracts with a professional medical firm to conduct annual medical audits of all AHCCCS health plans.

Finally, AHCCCS said that all available research, since the program's inception, indicates that AHCCCS beneficiaries are receiving quality health care. AHCCCS added that the results of the 1983-84 fiscal year medical audit disclosed reasonable service utilization patterns of primary care physicians to AHCCCS beneficiaries. Furthermore, according to AHCCCS, an independent survey of Arizona's indigent population showed that access to health care services has improved for AHCCCS beneficiaries, that they are pleased with the care received, and that they want to retain the AHCCCS approach to providing health care.

In June 1984 we testified that neither HCFA nor the state had adequate information to protect beneficiaries from underservicing or poor quality of care.[8] Specifically, we noted that

- some contracting providers did not have complete written quality assurance plans;
- considerable AHCCCS utilization experience was missing, limiting HCFA's and the state's ability to flag possible underservicing or poor quality care.
- an adequate grievance process had not yet been fully implemented; and
- a HCFA medical advisor had found some weaknesses in the initial medical audit of health plans' operations and made suggestions to increase their future reliability.

[8]Statement of Michael Zimmerman, Associate Director, Human Resources Division, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

The state has taken actions to correct these problems. The effectiveness of these actions will be discussed in our overall report on AHCCCS operations to be issued in the spring of 1986. However, it should be emphasized that these actions do not diminish the need to assure compliance with federal disclosure laws.

Purpose and Scope

Our report seems critical of its competitive market approach, according to AHCCCS. Specifically, AHCCCS said that the purpose and scope of our review were compromised because we cited case examples from the prepaid health plan experiment in California. AHCCCS added that the examples appear to make AHCCCS' health plans guilty of wrongdoing by association.

The case example from the California experiment is included in the background section to illustrate the potential adverse effects related-party transactions can have in a prepaid health care environment. It is not intended to imply that all related-party transactions are inappropriate or that a competitive approach is inappropriate, but to demonstrate the need for effective oversight and monitoring of such transactions to assure their appropriateness. The disclosure requirements developed after the problems identified in the California experiment provide the basis for assessing the appropriateness of related-party transactions and thereby avoiding the problems that arose in California.

HHS Comments

HHS agreed with our recommendations that (1) AHCCCS be required to review the reasonableness of related-party transactions, (2) contracts between AHCCCS and providers that do not disclose ownership and control arrangements be terminated, and (3) procedures be established to ensure that HCFA does not approve future Medicaid contracts lacking required disclosures. According to HHS, actions have been or will be taken to implement the recommendations.

The Department noted that since HCFA was informed of our findings in June 1985, it has imposed a new special condition on the state requiring it to comply with the disclosure requirements. Further, HHS said that no federal financial participation will be available after October 1, 1985, for providers that fail to supply the information. According to HHS, the state has accepted the new condition and has taken steps to obtain full disclosure from plans as part of the process of awarding fourth-year contracts to providers. HHS said that HCFA will monitor the state to assure that it fully complies with disclosure requirements in the future.

Although HHS agreed to establish procedures to monitor AHCCCS' contract approval procedures, it commented that AHCCCS, not HCFA, approves Medicaid contracts.

We believe that actions HHS has taken, or plans to take, to assure compliance with disclosure requirements should help prevent possible diversion of AHCCCS funds from their intended purpose, the provision of health care to AHCCCS beneficiaries.

Regarding our recommendations that it retrospectively review ownership and control and related-party transaction disclosures to determine the availability of federal financial participation, HHS believes that the effort and expense required to retrospectively obtain additional disclosure information is not warranted. Further, HHS said Arizona's reinvestigation of our findings demonstrated that AHCCCS plans were in "substantial" compliance with the federal statute and regulation.

HHS said that the noncompliance should be viewed in the context of (1) the program's start-up problems, which consumed so much time that other administrative activities were performed only on a "must do" basis, and (2) the inexperience of AHCCCS health plans, most of which were created specifically for the program, in complying with federal disclosure requirements.

HHS noted that since the state took over the operation of the AHCCCS program from the private administrator in March 1984, AHCCCS had committed enormous resources toward rectifying all of its problems. According to HHS, the Peat Marwick report used as a source for many of the facts in our report was commissioned by the state. HHS said that the state's response to the Peat Marwick report was to aggressively monitor the management of plans shown to be in serious financial difficulty. The state, according to HHS, arranged for one of the plans to be taken over by new management and successfully arranged for the transfer of AHCCCS beneficiaries to other plans from the plans that failed.

HHS said that although AHCCCS technically should have required new disclosures when it renewed third-year AHCCCS contracts, the state felt that with the second-year submissions and with a recent audit report, it had met its obligation to acquire this information.

The reasons cited by HHS for the noncompliance with the disclosure requirements—start-up difficulties and inexperience with federal requirements—are the primary reasons why HCFA should have been

providing oversight and guidance to the state to ensure compliance with federal requirements. Further, the disclosure problems resulted more from the lack of enforcement actions than from inexperience with federal requirements. AHCCCS established specific requirements for disclosure of ownership and control arrangements (see p. 12) and related-party transactions (see p. 13) by AHCCCS plans that were consistent with the federal requirements. Accordingly, noncompliance with the disclosure requirements cannot, in our view, be justified on the basis of the plans' inexperience with the federal requirements.

We do not agree with HHS' conclusion that further investigation of the disclosure problems to determine the availability of federal financial participation is not warranted. As discussed on pages 12 and 14 and in appendix VI, we do not agree that the state's reinvestigation showed the AHCCCS plans to be in compliance. Furthermore, the disclosure problems may play an important part in ongoing fraud investigations of AHCCCS health plans by Arizona's Attorney General.

The 1985 annual report prepared by the Attorney General's AHCCCS Fraud Investigation and Prosecution Unit states that the unit is pursuing allegations of fraud in the operation of three AHCCCS health plans. According to the report, the investigations are primarily focused on patterns of criminal activity involving kickbacks, embezzlement, false claims to the government, willful concealment from the government, and illegal control of an enterprise (racketeering).

According to the Annual Report,

"The AHCCCS Fraud Unit's largest and most complex case involves the State's largest health plan, with 30 to 35 million dollars in losses. Our evidence indicates that certain highly placed corporate officials of the health plan used their positions to divert corporate funds into various accounts of corporations owned or controlled by those officials. These funds were distributed to the officials and to others, sometimes under the guise of consulting fees, and sometimes as outright embezzlements. A sizeable portion of these funds were paid to the principals as kickbacks, in a fashion similar to racketeering activities surrounding the Teamsters Welfare Fund and its health care related business . . .."

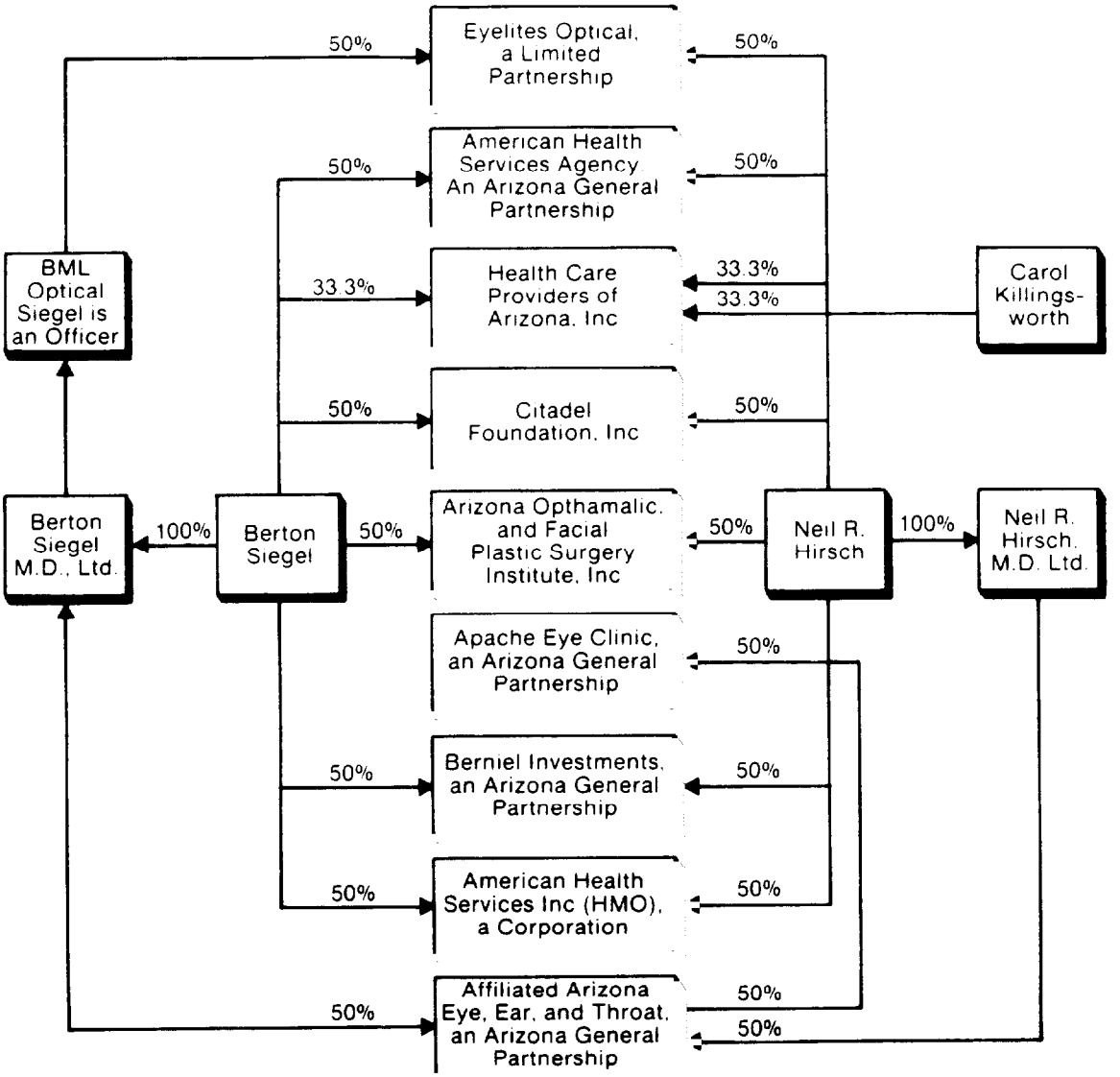
The Assistant Attorney General in charge of the fraud unit told us that if the state can prove that a health plan failed to file (or filed a false) state-required quarterly financial statement or federal- or state-required

report on related-party transactions with intent to defraud, it can obtain a felony conviction.

Accordingly, we continue to believe that HCFA should investigate the extent of past noncompliance and the reasons for it. Determinations on the availability of federal financial participation for services provided by nondisclosing plans should, in our opinion, be made only after completion of the reviews by HCFA and the fraud investigations by the Attorney General's office.

Health Care Providers of Arizona and Affiliates Organization Chart

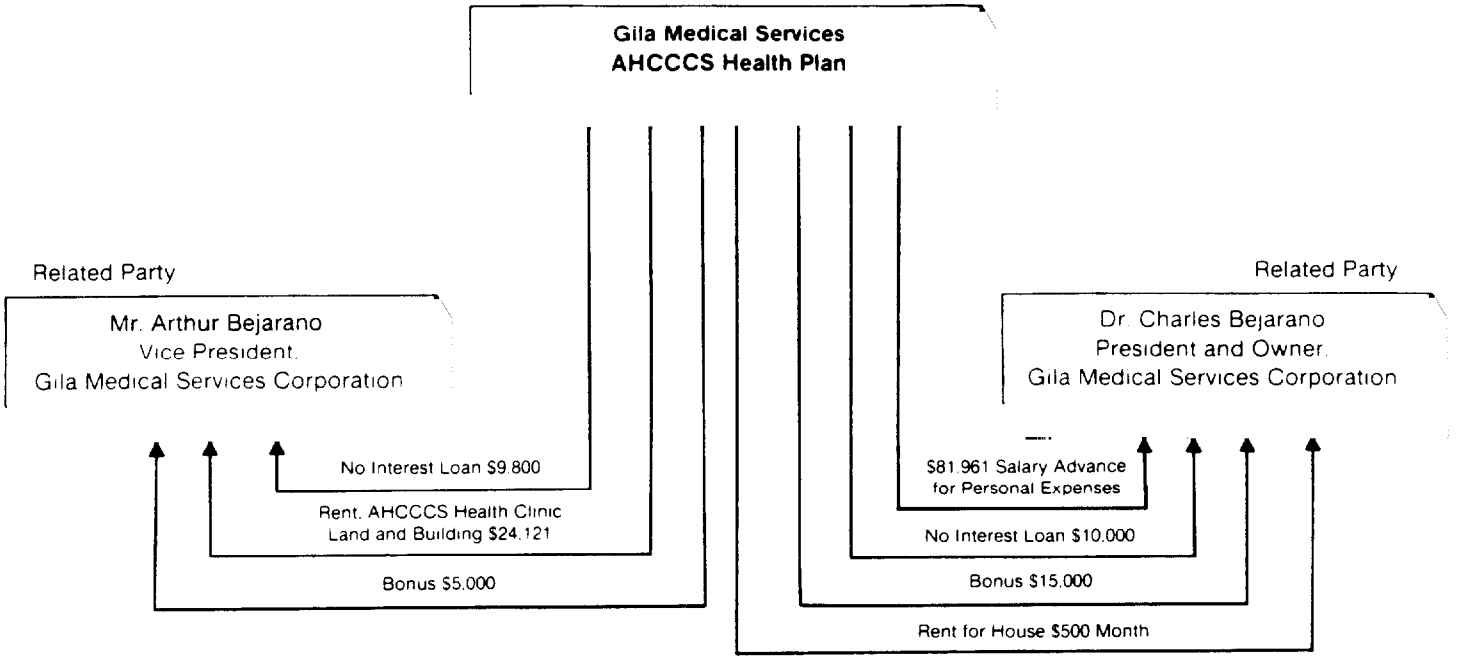
Health Care Providers of Arizona and Affiliates Organization Chart



Source: Peat, Marwick, Mitchell Report on the Financial and Compliance Review of Plan Operations Conducted for Arizona Health Care Cost Containment System, August 1984.

Gila Medical Services Corporation (AHCCCS Health Plan)

Gila Medical Services Corporation



Based on related party transactions during health plan's first 18 months of operation. Of these transactions, only salary and bonuses were disclosed to state as of June 3, 1985, by the plan.

Source: Peat, Marwick, Mitchell, report on the financial and compliance review of plan operations conducted for Arizona Health Care Cost Containment System, August 1984.

Summary of AHCCCS Plans' Noncompliance With Ownership/Control Disclosure Requirements

AHCCCS health plan	Information not submitted for second-year contracts: Direct/ indirect ownership interest	Information not submitted for second-year contracts: Listing of board of directors
Comprehensive AHCCCS, Inc.		X
Family Health Plan of Northeastern Arizona	X	
Northern Arizona Family Health Plan, Inc.	X	
Health Care Providers of Arizona, Inc.	X	

Summary of AHCCCS Plans' Disclosure Of Related-Party Transactions As of June 21, 1985

Table V.1: Disclosure by First-Year (1982-83) AHCCCS Health Plans

	Statement filed timely (due 12/31/83)[a]	Statement not filed	Statement filed late (date)
Arizona Family Physicians IPA		X	
Coconino Health Plan		X	
Western Sun Associates, Inc.			4/17/84
Comprehensive AHCCCS Plan, Inc.			4/23/84
Douglas Clinic		X	
Dynamic Health Services, LTD		X	
El Rio Santa Cruz Neighborhood Health Center, Inc.		X	
Gila Medical Services Corporation		X	
Health Care Providers of Arizona, Inc.			4/09/84
Maricopa County Dept. of Health Services		X	
Samaritan Health Service		X	
Mt. Graham Community Health Plan, Inc.		X	
No. Arizona Family Health Plan, Inc.			4/02/84
Pima Health Maintenance Group, Inc.[b]	•	•	•
Pima County Board of Supervisors		X	
Pinal General Hospital		X	
CIGNA Health Plan[b]	•	•	•

[a]Date by which AHCCCS requested information.

[b]Because they are federally qualified health maintenance organizations, these plans were not subject to this reporting requirement.

Table V.2: Disclosure by Second-Year (1983-84) AHCCCS Health Plans

	Statement filed timely (due 12/31/84)[a]	Statement not filed	Statement filed late (date)
Access Patients' Choice, Inc.			2/13/85
Arizona Family Physicians IPA		X	
Western Sun Associates, Inc.			5/23/85
Comprehensive AHCCCS Plan, Inc.		X	
Dynamic Health Services, LTD		X	
El Rio Santa Cruz Neighborhood Health Center, Inc.		X	
Family Health Plan of Northeastern Arizona, Inc.		X	
Gila Medical Services Corporation			6/03/85
Graham Co. Dr. Health Plan, P.C.			4/11/85
Health Care Providers of Arizona, Inc.	X		
Maricopa County Department of Health Services	X		
Samaritan Health Services		X	
No. Arizona Family Health Plan, Inc.			6/05/85
Phoenix Memorial Hospital	X		
Pima County Board of Supervisors			2/15/85
Pinal General Hospital		X	
St. Joseph's Hospital and Medical Center			2/20/85
University Physicians			2/22/85
CIGNA Health Plan[b]	•	•	•

[a]Date by which AHCCCS requested information.

[b]Because it is federally qualified health maintenance organization, this plan was not subject to this reporting requirement.

Analysis of Supplemental Information Supplied by AHCCCS on Disclosure Requirements

On June 12, 1985, we briefed AHCCCS officials on the results of our review and gave them the names of five AHCCCS plans for which we were unable to find submissions disclosing ownership and control arrangements. In a June 21, 1985, letter, the AHCCCS Director submitted additional records that he believes shows that AHCCCS was in "substantial" compliance with the spirit and letter of the disclosure regulations for the second contract year (1983-84).

This appendix contains a summary of the information AHCCCS provided and our analysis of it. For one of the five plans, the additional documents supplied by AHCCCS satisfy the second-year ownership and control disclosure requirements. However, as discussed below, we do not believe the additional information satisfies the disclosure requirements for the other four plans.

Health Care Providers of Arizona, Inc.

According to the AHCCCS Director, AHCCCS and Health Care Providers complied with the ownership and control disclosure requirements of 42 C.F.R. 455.104. The Director stated that it was common knowledge, based on Health Care Providers' first-year AHCCCS proposal and the corporation's filing with the Arizona Corporation Commission, that the plan's three codirectors were also its equal owners. He also pointed out that Health Care Providers' submission of the required information in a January 1983 proposal to provide health services to state employees and certain other non-Medicaid beneficiaries was within 12 months of contracting for AHCCCS' second year as required by the regulations.

In our opinion, the information the AHCCCS Director supplied to us does not demonstrate that AHCCCS and Health Care Providers were in compliance with the disclosure requirements. None of the documents explicitly identified the plan's owners as is required by the disclosure regulation, although the state said it knew who owned the plan. Furthermore, no ownership and control information was provided to HHS, as the disclosure regulation specifies.

AHCCCS argues that the state knew who owned the plan from the first-year bid proposal and from information filed with the Arizona Corporation Commission. Neither of the documents meets the disclosure requirements. The first-year bid proposal was too old to satisfy the second-year disclosure requirements, and AHCCCS did not have the information filed with the Arizona Corporation Commission. The regulations require that

the provider reveal ownership and control interests to the state Me caid agency, not that it be available from another state agency or commission.

Comprehensive AHCCCS Plan, Inc.

AHCCCS stated that Comprehensive AHCCCS Plan, a private, nonprofit poration, complied with applicable requirements by listing all perso with direct and indirect ownership interests in a June 27, 1983, clar cation to its second-year bid proposal. According to the AHCCCS Dire AHCCCS was informed by the plan's administrator that all persons w ownership and control interests in the corporation at that time were included in the bid proposal clarification. AHCCCS also provided copi the plan's periodic ownership and control reports submitted throug June 1984.

The plan did not comply with the disclosure requirement. Neither t ownership and control reports nor the bid proposal clarification ide fied the members of the board of directors, who must be disclosed because they are persons with an ownership or control interest.

The materials cited by AHCCCS also contained inconsistent informati For example, ownership and control reports indicated that there we no direct or indirect ownership interests in the plan although the bi proposal clarification identified 19 such persons or entities.

Northern Arizona Family Health Plan, Inc.

According to the AHCCCS Director, Northern Arizona Family Health Plan's first contract proposal, submitted August 6, 1982, included owr ership and control information. He said that he believes the plan supplied required information for the second contract year but indicate that AHCCCS has been unable to locate the proposal. The Director als enclosed an ownership and control report submitted by the plan in . 1983 as further evidence of compliance with the disclosure requirements.

Our initial findings with respect to Northern Arizona Family Healt Plan were based on a review of the second-year contract proposal t AHCCCS indicated it was unable to locate. The additional informatio plied by AHCCCS does not demonstrate that the plan made full and c plete disclosure because not all members of the board of directors w disclosed.

Family Health Plan of Northeastern Arizona

According to the AHCCCS Director, Family Health Plan of Northeastern Arizona included a listing of key personnel, including all persons with ownership and control interests, in a June 29, 1983, clarification to its second-year contract proposal. The Director also enclosed an ownership and control report submitted by the plan.

Neither the materials cited nor the other information we reviewed, including the original second-year proposal, described the plan's ownership and control arrangements as required by the regulations. Specifically, members of the board of directors were not disclosed by the proposal or the proposal clarification. Nor were the names and addresses of individuals or organizations having ownership interests disclosed.

The plan later filed a disclosure statement listing the members of the board of directors, 7 months after the beginning of the contract year. It was too late to allow the state or HCFA to review any possible contractual shortcomings revealed by ownership and control information.

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington D.C. 20201

SEP 27

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, "Noncompliance With Disclosure Requirements by Health Plans Participating in Arizona's Medicaid Program." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

for Richard P. Kusserow
Inspector General

Enclosure

management of plans shown by the report to be in serious financial difficulty. The State arranged for one of the plans to be taken over by new management and successfully arranged for the transfer of AHCCCS beneficiaries to other plans from the plans that failed.

In the third year of the AHCCCS program, the State renewed all AHCCCS health plan contracts for another year. Although technically it should have required new disclosures, the State felt that with the second year submissions and with a recent audit report, it had met its obligation to acquire this information.

HCFA was informed of the findings of the GAO report in June of 1985. At that time, HCFA was still in the process of considering the request from the State of Arizona to continue the AHCCCS program for another 2 year period. In approving the State's continuation application for only 1 year, HCFA imposed a new special term and condition on the State requiring it to comply with the disclosure requirements. Further, no Federal financial participation (FFP) will be available after October 1, 1985 for providers that fail to supply this information. The State has accepted the new term and condition and has taken steps to obtain full disclosure from plans as part of the process of awarding contracts to providers for the fourth year of the demonstration. HCFA will monitor the State to assure that the State fully complies with disclosure requirements in the future.

GAO Recommendations

That the Secretary, Department of Health and Human Services, direct the Administrator, HCFA, to:

- Review AHCCCS plan contract proposals and renewal submissions to determine whether health plans complied with the ownership and control disclosure requirements and determine the extent to which FFP should not be available for payments made to AHCCCS health plans that did not comply;
- obtain from each health plan that did not provide full and complete disclosure of related party transactions in a timely manner an explanation of the reason(s) for nondisclosure and, based on an evaluation of those reasons, determine the extent to which FFP should be recouped for period(s) of nondisclosure;

Department Comment

We believe that the amount of effort and expense required to retrospectively obtain disclosure information is not warranted. Further, Arizona's reinvestigation of the GAO findings demonstrates substantial compliance with the Federal statute and regulations.

GAO Recommendations

- direct AHCCCS to review the reasonableness of reported related party transactions to ensure that they do not divert capitation payments away from health care;
- ensure that contracts between AHCCCS and any provider that does not disclose ownership and control arrangements are terminated; and,

Department Comment

We agree and will take appropriate actions to implement these recommendations. As discussed above, a new term and condition of the continuation application requires the State to comply with the disclosure requirements, and FFP will not be available after October 1, 1985 for providers that fail to supply this information.

GAO Recommendation

- establish procedures to ensure that HCFA does not approve future Medicaid contracts that are lacking required disclosure of ownership and control arrangements.

Department Comment

Although the State Medicaid agency and not HCFA approves Medicaid contracts, HCFA will establish procedures to monitor Arizona's activities in this area.

Advance Comments From the Governor of Arizona

BRUCE BABBITT
GOVERNOR

OFFICE OF THE GOVERNOR
STATE HOUSE
PHOENIX, ARIZONA 85007

IN REPLY REFER TO

September 20, 1985

Mr. Richard L. Fogel
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The AHCCCS Administration has reviewed the recent GAO report addressing disclosure requirements for AHCCCS health plans. Attached you will find our comments.

Our major concern with the report is that little is said about the many positive steps the State has taken since we assumed full administrative responsibilities for the program in March 1984. Additionally, the inclusion of the California program is particularly troubling in light of the major efforts we have made to avoid the situations which arose in California.

All available research indicates that the AHCCCS approach for delivering health care to indigent recipients is effective. The program delivers quality health care while containing costs.

Sincerely,

Bruce Babbitt
Governor

BB:dpb

Attachment

The Administration finds the report, however, incomplete and extraneous in certain sections. It is incomplete because it omits substantive action taken by the Administration to make AHCCCS be in compliance with the federal disclosure requirements. It is extraneous because it draws upon inconclusive California incidents of purported wrongdoing.

Therefore, the intent of this response is to help the United States General Accounting Office submit a comprehensive and objective report to the Honorable Henry A. Waxman, Chairman of the Subcommittee on Health and the Environment, U.S. House of Representatives.

Financial and Compliance Review

One of the first administrative actions initiated by the State AHCCCS Administration in April of 1984 was to contract with one of the big eight accounting firms to review the health plan contractors. Peat, Marwick, Mitchell and Company (hereinafter referred to as PMM) received the contract to conduct a financial and compliance review of the nineteen health plans from the inception of AHCCCS through March 31, 1984. Upon receipt of the review findings, the AHCCCS Administration provided the State Attorney General's Office with a copy of the report recommending that the related party transactions and ownership relationships be examined. In response, the Attorney General's Office initiated a comprehensive investigation into certain health plan activities. The results of this investigation will soon be made public.

Now on p. 13.

The proposed GAO report does not state what the AHCCCS Administration did upon receipt of the PMM report (page 12). Accordingly, this information should be added to the GAO report.

These operational and structural changes demonstrate that the current AHCCCS Administration has taken aggressive and positive action in the past 18 months to ensure that health plan contractors make full and complete disclosure of ownership and control arrangements and related party transactions. These substantive actions show that the Administration never intended to use the PMM report and financial audits of plan operations as an alternative to disclosure of related party transactions by the plans (pages 12 and 13 of the proposed report). Thus, the GAO Report should include many, if not all, of these points to show the commitment of AHCCCS to be in compliance with the federal disclosure requirements.

Now on pp. 13 and 14.

Purpose and Scope

The AHCCCS program is based on a competitive market approach. Three principal tenants of this approach are: competitive pricing, prepaid capitated payments and cost containment. The proposed report seems critical of AHCCCS' approach.

The proposed report cites several California case examples implying that an impropriety occurred in a Medicaid prepaid health plan environment. One plan retained 5 percent of the funds for internal expenses while the remainder flowed to affiliated for-profit firms (page 6). Another firm provided administrative services to a plan deriving about 41 percent of its revenue from the plan and realizing an 18.5 percent profit (page 6).

Now on p. 10.

Now on p. 10.

One cannot conclude based on the anecdotal information provided for these two cases that a statutory violation occurred. One might surmise that the health plan was operating efficiently and that the management firm received just compensation for services rendered. Is an 18.5 percent profit automatically excessive or illegal?

All available research, since the program's inception, indicates that the AHCCCS members are receiving quality health care. The results of the 1983/84 fiscal year medical audit completed September 30, 1984, discloses reasonable service utilization patterns of primary care physicians to AHCCCS members. Furthermore, the Flinn Foundation found through the Louis Harris organization survey of Arizona's indigent population in 1984 that the AHCCCS program is working. Specifically, it found that access to health care services for people enrolled in AHCCCS has improved, that AHCCCS members are pleased with the care they receive, and that the members want to retain the AHCCCS approach to providing health care.

2063S

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.