BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

10,067

Health Maintenance Organizations: Federal Financing Is Adequate But HEW Must Continue Improving Program Management

The 1978 amendments to the Health Maintenance Organization Act required GAO to determine whether Federal grants and loans are adequate to help develop new health maintenance organizations (HMOs) and expand existing ones, and to evaluate the effectiveness of the policies and procedures for administering these programs.

Viable, well-managed HMOs should need no more than $4 million--the amount specified by law--to cover operating losses and should be able to achieve financial independence within 5 years after becoming qualified. In order to minimize the Government's risk on loans to HMOs, HEW needs to develop a strategy to assess the financial soundness of an HMO.

HEW's Office of Health Maintenance Organizations has improved its administration of the program since June 30, 1978, but needs to expedite its efforts to issue formal policies and regulations, see that staffing shortages do not occur, and provide adequate guidance to regional personnel who help administer the grant program.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives CWO 00001

This report summarizes our evaluation of (1) the adequacy of the amounts of financial assistance provided for under the Health Maintenance Organization Act, as amended, and (2) the adequacy of the policies and procedures established by the Department of Health, Education, and Welfare to administer the financial assistance programs established by the act, as amended.

Section 13 of the Health Maintenance Organization Amendments of 1978 (Public Law 95-559) required that we make these evaluations and directed us to report the results to the Congress by May 1, 1979.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

HEALTH MAINTENANCE ORGANIZATIONS: FEDERAL FINANCING IS ADEQUATE, BUT HEW MUST CONTINUE IMPROVING PROGRAM MANAGEMENT

D I G E S T

Adequate loan assistance is available to health maintenance organizations (HMOs) to finance their operating losses. Viable, well-managed HMOs should need no more than $4 million--the amount specified by law--to cover operating losses and should be able to achieve financial independence within 5 years after becoming qualified.

GAO had these and the following observations on HMO financing and operations:

--The key to an HMO's financial success is its ability to charge competitive rates which generate sufficient revenues per member to cover the costs of operation and provide sufficient additional funds to repay debts, replace facilities, and finance future growth.

--To minimize the Government's financial risk, decision points should be established to assess the financial viability of HMOs with Federal loans.

--The HMO legislation provides for adequate loan assistance to acquire or construct and equip ambulatory health care facilities.

The results of a questionnaire sent to grantees and qualified HMOs indicated that the act, as amended, provides for adequate grant assistance. However, because of budget uncertainties for the fiscal year 1979 grant program, the number of HMOs becoming qualified in later years could decrease.

ADMINISTRATION OF LOANS AND GRANTS CAN BE IMPROVED

As of April 1, 1979, the Department of Health, Education, and Welfare (HEW) had not issued formal policies for administering HMO loan programs, although considerable progress had been made toward completing them.

The headquarters-based Loan Branch had enough staff for fiscal year 1979 but may be understaffed for the surge of applications expected to result from the ambulatory health care facility loan program.

HEW had improved its capability to monitor the continued financial soundness of HMOs with Federal loans but had not issued policies and procedures for assessing compliance with the act, and compliance staffing problems may recur as more HMOs are qualified.

HEW had not established adequate guidance on policies and procedures to assure uniform, consistent administration of the grant program by regional and headquarters personnel. However, as of March 1, 1979, HEW was developing policy and procedure guidance to help grantees move smoothly through the grant phases into qualification. HEW's work in this area was not far enough along for GAO to assess its eventual effectiveness.

GAO also found that two regional offices were understaffed to handle their fiscal year 1979 workplans.

RECOMMENDATIONS

The Secretary of HEW should:

--Establish a development strategy which guides new HMOs to plan for only enough staff and facilities to enroll and serve enough members during their initial stages of operation for the HMOs' current costs per member month to become relatively stable. GAO observed that current costs

per member month of HMOs it evaluated generally had become relatively stable by the time they enrolled 10,000 members. In some cases, their costs per member month had leveled and begun to increase. HEW should further study this phenomenon to develop more definitive data.

The point at which an HMO's costs per member month become relatively stable could provide a baseline for actuarially projecting the HMO's future costs per member. After future costs per member are projected, HEW could actuarially assess whether the subscriber rates which the HMO would need to achieve financial independence would be competitive. This procedure could provide a point at which HEW could assess the HMO's ultimate financial viability before the HMO's Federal loan funds are exhausted. Such an assessment could provide guidance to HEW and the HMO on the enrollment growth patterns most likely to result in financial independence.

--Assign enough staff to complete work on policies for the deficit loan program and regulations and policies for the ambulatory health care facility loan program and see that these regulations and policies move quickly through departmental review levels.

--Assess the impact of the ambulatory health care facility loan program on the workload of the Office of Health Maintenance Organization's Loan Branch to assure that the branch is adequately staffed when the new loan program begins.

--Take action needed to assure that required reports from qualified HMOs are submitted more promptly.

--Assess the impact of an increasing number of qualified HMOs on the Office's ability to monitor their compliance so that additional staff can be assigned promptly, if required.

--Give priority to validating HMO report data, completing a summary of compliance policies and procedures in order to assure uniformity, and rendering a decision on regional responsibilities.

--Develop improved grant program guidance for regional offices as soon as possible.

--Publish guidelines defining the requirements for qualified HMOs as soon as possible.

AGENCY COMMENTS AND GAO'S EVALUATION

In a draft of this report furnished to HEW for comment, GAO's proposal for a development strategy for loans to new HMOs suggested that initial loans be based on expected operating deficits that would be incurred until an HMO reached an enrollment level of 8,000 to 10,000 members--the point at which GAO observed that costs per member month became relatively stable. In commenting on this report, HEW expressed the view that its HMO development strategy and its assessments of financial viability should not focus strongly on GAO's observation that the costs per member month of the HMOs evaluated tended to cease declining by the time they had enrolled 10,000 members. HEW pointed out that GAO's analysis had not considered inflation and that the sample size was small.

However, HEW stated that it found GAO's analysis informative and useful. HEW added that the analysis would provide a benchmark to identify HMOs with potential financial problems and to begin focusing on the use of revenues when an HMO's costs per member first begin to level off. At that time, HEW plans to make a more indepth financial analysis and, if necessary, take corrective action.

After evaluating HEW's comments, GAO modified its recommendation concerning a development strategy for new HMOs to emphasize cost stability rather than enrollment size. GAO believes that HEW's plans and comments meet the intent of the recommendation, and GAO encourages HEW to do further study in this area to develop more fully this tool for assessing HMO financial viability and minimizing the Government's financial risk.

HEW concurred in all of GAO's other recommendations and outlined actions either planned or underway to implement them.

Contents

ABBREVIATIONS

CPMM	costs per member month
GAO	General Accounting Office
HANC	Health Alliance of Northern California
HEW	Department of Health, Education, and Welfare
HMO	health maintenance organization
OHMO	Office of Health Maintenance Organizations
RPMM	revenues per member month
SHA	Sound Health Association

CHAPTER 1

INTRODUCTION

Curbing the escalation of medical care costs is a major goal of both the administration and the Congress. Pursuant to that goal, the Secretary of Health, Education, and Welfare has made a commitment to give significant numbers of people across the Nation the opportunity to enroll in health maintenance organizations (HMOs). HMOs contract with individuals to provide them specific health services in return for a prepaid fixed payment. The fixed income feature gives HMOs a financial incentive to control use of health services and to emphasize preventive medicine to reduce overall health care costs.

The HMO Act of 1973 (Public Law 93-222) authorized a program to provide grants and loans to help develop new HMOs and expand existing ones. 1/ In September 1976 and June 1978, we reported on problems the Department of Health, Education, and Welfare (HEW) had encountered implementing and managing the financial assistance programs. 2/

Section 13 of the HMO Amendments of 1978 directed us to evaluate (1) the adequacy of the amounts of assistance available under grant and loan programs established under the act and (2) the adequacy and effectiveness of HEW's policies and procedures for managing the grant and loan programs. Section 13 directed us to report the results of the evaluations to the Congress by May 1, 1979.

1/The HMO Act of 1973 was amended in October 1976 by the HMO Amendments of 1976 (Public Law 94-460) and in November 1978 by the HMO Amendments of 1978 (Public Law 95-559).

2/"Factors That Impede Progress In Implementing The Health Maintenance Organization Act Of 1973" (HRD-76-128, Sept. 3, 1976).

"Can Health Maintenance Organizations Be Successful?--An Analysis Of 14 Federally Qualified HMOs" (HRD-78-125, June 30, 1978).

FEDERAL FINANCIAL ASSISTANCE UNDER THE HMO ACT

Through February 1979, HEW had certified 88 HMOs as complying with the requirements of the act; such HMOs are called "qualified" HMOs. 1/ The act, as amended in 1976, authorized HEW to lend each qualified public or nonprofit HMO up to $2.5 million to cover operating losses during its first 5 years of operation as a qualified HMO. In the case of a private, for-profit HMO serving a medically underserved area, HEW could guarantee loans of up to $2.5 million made to the HMO by private lenders.

The HMO Amendments of 1978 raised the ceiling on loans and loan guarantees from $2.5 million to $4 million, effective October 1, 1979. However, HEW may loan an HMO more than $2.5 million before October 1979, if the Secretary (1) determines in writing that it is necessary to preserve the fiscally sound operation of an HMO and to protect against insolvency and (2) notifies in writing the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce within 30 days after making the loan.

As of February 1979, 58 of the 88 qualified HMOs had received direct loans totaling about $119.3 million, and 3 HMOs had received loan guarantees totaling about $3.5 million. One HMO had received loans exceeding $2.5 million.

To encourage development of new qualified HMOs and to expand existing qualified HMOs, the act, as amended, authorizes grants to public or nonprofit organizations for feasibility studies, planning, and initial development. Through February 1979, HEW had awarded feasibility grants, planning grants, and initial development grants totaling about $80.5 million. 2/

FEDERAL HMO PROGRAM ORGANIZATION

The HMO Amendments of 1976 required HEW to centralize all HMO program responsibilities, except the qualification and compliance functions, under one organizational unit. In December 1977, HEW centralized the headquarters activities, including qualification and compliance functions, within the

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1/See app. I for a list of qualified HMOs receiving financial assistance as of December 31, 1978.

2/See app. II for summary of grant activity by fiscal year.

Office of the Assistant Secretary for Health. Effective March 1, 1978, HEW appointed a director for the centralized program, and on September 19, 1978, the Office of Health Maintenance Organizations (OHMO) was officially established. Program functions and staff were consolidated for the first time in one unified operation. OHMO has six major organizational components:

--Office of the Director implements the HMO program through five central office divisions and a field staff at 10 regional offices; coordinates policy and regulation development; develops a comprehensive strategy for national HMO development; maintains liaison with interested outside organizations and groups; and coordinates with the Department for intergovernmental and congressional liaison.

--Division of Development makes grant award recommendations and monitors grants, loans, and loan guarantees; directs and coordinates grant and loan management in the central and regional offices; establishes standards and procedures for HMO grant reviews and loan applications; and provides advice and assistance to individuals and organizations that seek to develop an HMO.

--Division of Qualification establishes qualification standards and determines acceptability of entities seeking to become qualified HMOs; refines review procedures to facilitate the qualification process; provides guidance on interpretation of policy guidelines and regulations related to qualification; and provides technical assistance to HMOs.

--Division of Compliance assures the continuing compliance of HMOs with the statutory requirements of the HMO act; monitors employers' compliance with mandatory offering of the HMO alternative in employee health benefits plans; reviews standards, procedures, and reporting requirements for monitoring HMOs that receive financial assistance; establishes and updates standards and procedures for compliance monitoring of qualified HMOs; and reviews fiscal viability of all qualified HMOs.

--Division of Program Promotion develops strategies to increase public awareness of the HMO concept and provides assistance to Federal, State, public, and private agencies to identify areas for HMO development; analyzes potential HMO development geographically and

by sponsor; coordinates promotional activities with national professional and trade organizations; arranges for development, publication, and distribution of promotional, educational, and guidance materials; and prepares the Annual Report to the Congress.

--Office of Program Support directs administrative, fiscal, and related management services; implements budget formulation, presentation, and execution; develops and maintains manpower management and work planning systems for the central and regional offices; coordinates personnel activities; manages administrative aspects of contract activities; and provides correspondence management.

SCOPE OF EVALUATION

Our review was made at the Office of Health Maintenance Organizations in Rockville, Maryland, and HEW regional offices in Atlanta (region IV), Chicago (region V), and Denver (region VIII). We talked to headquarters and regional personnel and reviewed records and files at OHMO headquarters and regional offices.

We sent a questionnaire concerning the grant and loan programs to 80 HMOs qualified as of December 31, 1978; 80 grantees that were using grant funds as of September 30, 1978; and 10 grantees whose grants had expired but were known to have a grant or qualification application in process as of September 30, 1978. 1/ Of the 170 organizations to which questionnaires were sent, 148 (about 87 percent) responded. The respondents included 66 qualified HMOs, 75 active grantees, and 7 inactive grantees.

We reviewed financial data submitted to HEW by 42 HMOs qualified by September 30, 1977. 2/ Thirty-three of the forty-two had obtained Federal loans or loan guarantees. We analyzed available financial data submitted through December 1978 and reviewed selected records and files maintained by OHMO to assess the HMOs' financial soundness.

1/App. III is a copy of the questionnaire.

2/One other HMO was qualified before September 30, 1977, but we were unable to obtain any data on it from HEW.

CHAPTER 2

LOAN ASSISTANCE AVAILABLE TO HMOs IS ADEQUATE

A primary goal of the HMO Act is to help establish HMOs as financially independent business enterprises. A qualified HMO must be able to generate enough revenues to pay operating costs (break even) within 5 years after qualification. Effective October 1, 1979, the act, as amended, will authorize HEW to lend a public or nonprofit HMO up to $4 million to cover operating losses incurred during its first 5 years of qualified operation. HEW also may guarantee loans of up to $4 million from private lenders to a private, for-profit HMO serving a medically underserved area.

Based on an evaluation of 42 HMOs and on responses to the questionnaire sent to HMOs and grantees, we concluded that:

--Generally, $4 million is adequate to cover operating losses during the first 5 years of operation and an HMO ought to be able to achieve financial independence within 5 years.

--The key to financial success of an HMO is its ability to charge competitive subscriber rates which generate sufficient revenues per member to cover the costs of operation and provide sufficient additional funds to repay debts, replace facilities, and finance future growth.

--To minimize risk to the Government, decision points must be established to assess the financial viability of HMOs with Federal loans.

LOAN ASSISTANCE IS ADEQUATE FOR FINANCIALLY VIABLE HMOs

In our opinion, three basic requisites must be met to reasonably assure an HMO's success as a business enterprise:

--Enough members must be enrolled to achieve maximum economies of scale and still provide quality care as anticipated by the legislation.

--Operational costs must be efficiently managed and controlled.

--Subscriber rates must be charged that will begin to produce, after 5 years of qualified operation, enough revenues per member to break even, repay debts, replace facilities, and finance future growth.

HMOs that can meet these requisites should find that $4 million or less is adequate to cover operating losses incurred in their first 5 years of qualified operation. HMOs that cannot meet these requisites probably will not meet the amended act's financial soundness requirement, not because Federal loan assistance is too limited, but because they have been mismanaged or simply lack viability as a business venture. The level of assistance authorized by the act should be based on what a well-managed, viable organization needs to become financially independent. Otherwise, the amounts which could be justified are limitless.

As part of our evaluation, we analyzed the financial experience of 42 HMOs qualified as of September 30, 1977, 33 of which had obtained direct loans or loan guarantees. By late 1978, 2 of the 33 HMOs with loans or loan guarantees had reached the point of insolvency. One of the two was sold, and the other went into receivership and was reorganized. We classified the remaining 31 HMOs into three groups, based on our assessment of their ability to achieve financial independence--that is, incur operating losses of no more than $4 million and break even within 5 years.

Good chance--Fifteen HMOs were placed in this category because they had already reached their break-even points or their operating experience gave us no basis to question their ability to achieve financial independence as required by the act. 1/

Fair chance--Ten HMOs were placed in this category because, although their operating experience provided some favorable indications about their chances for success, we had some reservations about their ability to achieve financial independence as required by the act. For example, one HMO's monthly revenues per member were only 3 percent less than monthly costs per member as of September 1978; however, its costs per member had become relatively constant at a level of $36 to $38 per month, which is somewhat higher than the general experience of other qualified HMOs we evaluated. (See pp. 7 to 10.)

1/Five of the HMOs with a good chance had reached their break-even points in less than 5 years after becoming qualified and with deficits of less than $2.5 million.

In another case, the HMO's monthly revenues per member were only 4 percent less than costs per member; however, for the year ended September 1978, its monthly costs per member had increased 14 percent to $39 per member, which is relatively high compared to many other HMOs.

Poor chance--Six HMOs were placed in this category because their operating experience gave few or no favorable indications for success and raised major doubts about their ability to achieve financial independence as required by the act. 1/ Detailed examples of two HMOs in this category are presented on pages 14 to 20.

THE KEY TO FINANCIAL INDEPENDENCE IS SUFFICIENCY OF SUBSCRIBER RATES

Generally, the experience of HMOs we evaluated showed that they initially had been able to reduce average costs per member month as their enrollment increased. However, ignoring inflation, we observed that most HMOs' average costs per member month tended to become relatively stable as membership grew--that is, the rate of decline in costs per member month decreased to near zero as enrollment grew. 2/ We observed that this phenomenon generally occurred by the time an HMO had 10,000 members. In some cases, the HMOs' average costs per member had ceased to decline and had begun to increase, even though enrollment continued to grow.

Enrollment growth may, but not always, be a positive step toward reaching self-sufficiency as envisioned by the HMO Act. If an HMO is incurring costs per member month greater than revenues per member month, increased enrollment may help to close the gap by reducing average costs per member. However, it should be recognized that, if enrollment

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1/One of the six HMOs placed in this category has informed OHMO that it has tentatively decided to declare bankruptcy.

2/In our analysis we did not take into account inflation because a reliable index for HMOs does not exist. The national medical cost index was not used because it is heavily influenced by the cost of hospital care, but by design HMO enrollees' hospital usage is supposed to be less than that of the fee-for-service sector population. Also, from the viewpoint of the Government as a lender of Federal funds, the financial viability of an HMO is appropriately measured by the relationship of the HMO's current costs to its current revenues.

growth does not help to lower average costs per member, enrollment growth will tend to increase the HMO's cumulative deficit and may exhaust available Federal loan funds before it can break even.

Because Federal loan funds are available to cover operating deficits for only a specified period and in a specified amount, an HMO's financial viability rests on the ability of management to balance two conflicting goals: competitive subscriber rates that allow enrollment growth versus subscriber rates that are high enough to generate the revenues per member needed to break even.

As we noted in our June 1978 report, HMOs' primary competitors are insurance companies that offer health benefit plans. Although qualified HMOs generally offer more comprehensive coverage than insurance company plans and may have more advantageous coinsurance features, HMOs cannot assume that consumers will readily switch to HMO coverage if an HMO's subscriber rates are substantially higher than the rates for insurance company coverage. Consequently, an HMO faces a serious problem: the HMO Act requires an HMO generally to provide more comprehensive benefits than its competitors, but the HMO must charge about the same subscriber rates as competitors in order to penetrate the health insurance market. However, an HMO may find that competitive subscriber rates which allow the HMO to capture an increasing share of the market are not high enough to produce the revenues per member needed to break even.

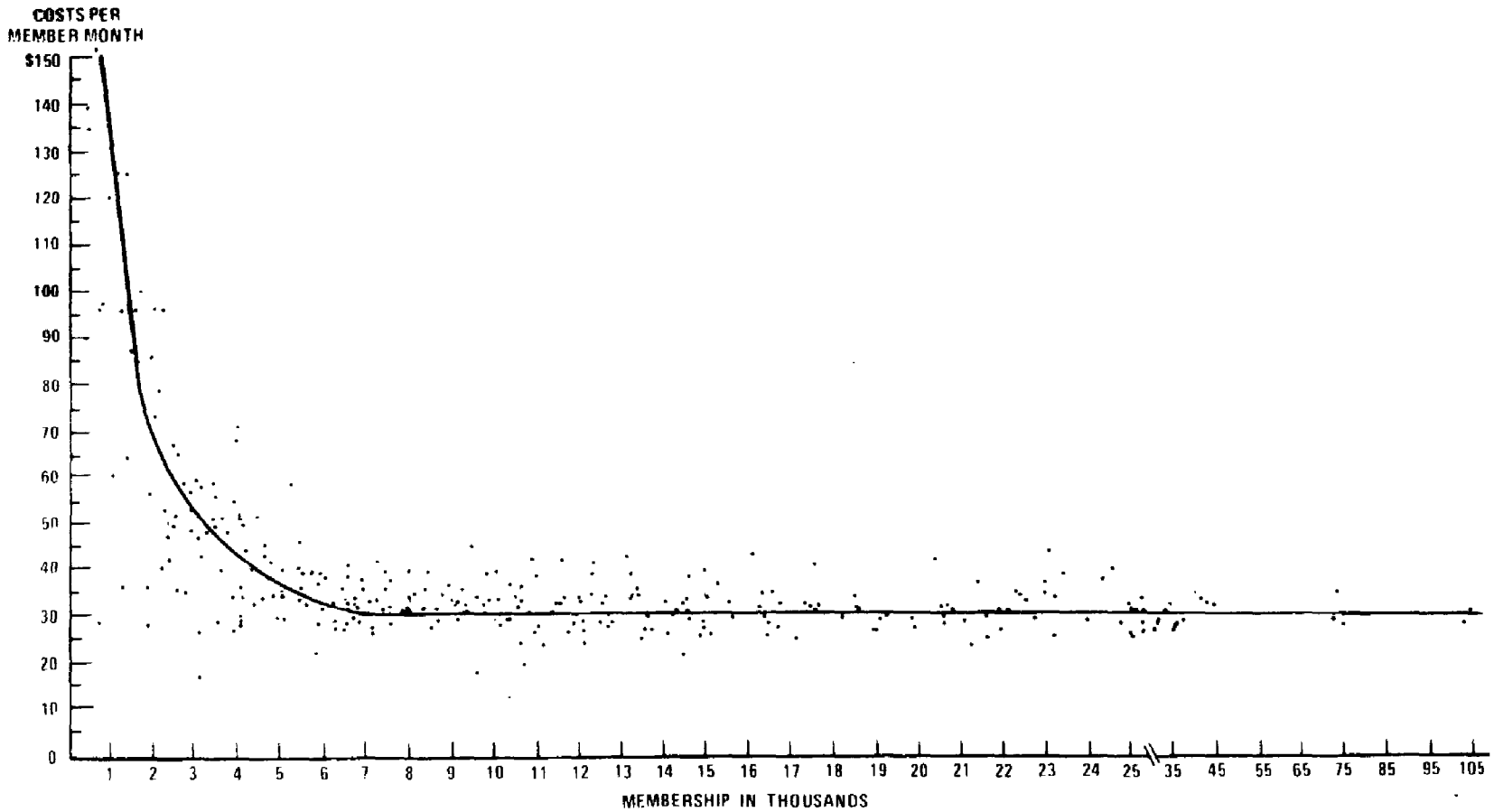
Our conclusions are supported by the experience of two HMOs that had become insolvent and the experience of other HMOs that have financial problems. From their experience, we concluded that overemphasis on enrollment growth may sometimes hurt a developing HMO's chances of achieving financial independence as required by the act.

HMOs do not need to be large to achieve lowest cost per member

Chart A depicts the composite cost experience of 42 HMOs qualified as of September 30, 1977. In general, the composite costs-per-member-month curve declined sharply as membership increased but the rate of decline decreased and costs per member eventually became relatively constant. We observed that the leveling of the costs-per-member curve usually occurred by the time HMOs enrolled about 10,000 members.

CHART A

COMPOSITE COST EXPERIENCE OF 42 QUALIFIED HMOs [a] THROUGH DECEMBER 1978 (NOTE b)



[a] One other HMO was qualified before September 30, 1977, but we were unable to obtain any data on it from HEW.

[b] Cost and membership data is based on data from unaudited quarterly reports submitted by HMOs to HEW under the HMO national data reporting requirements (OMB No. 68R-1496).

We also observed that the composite cost curve leveled in the vicinity of $30 per member month. 1/ Some individual HMOs' cost curves had leveled at higher than $30 and some lower, but even HMOs with more than 40,000 members had monthly costs ranging from about $28 to $35 per member.

The composite cost chart implies that (1) HMOs achieve economies of scale early in their existence in terms of enrollment and (2) enrollment growth alone will not cause any significant decreases in costs per member after their cost curves level in current dollars. Therefore, for an HMO whose monthly costs per member have leveled, enrollment growth is not the critical factor in achieving financial independence. Assuming the HMO has adequate utilization and cost controls, the crucial factor is the sufficiency of subscriber rates to generate the revenues per member needed to break even, repay debts, replace facilities, and finance future growth.

Case histories of two HMOs that became insolvent

Sound Health Association (SHA)

SHA became qualified in 1974 and obtained a $1 million Federal loan. It obtained additional loans of $228,000 in 1976 and $1.272 million in 1977, raising its total Federal loans to $2.5 million, the maximum allowable under the HMO Act at that time. However, by August 1978, SHA had lost about $2.49 million, and its financial position was deteriorating.

In September 1978, HEW deferred SHA's Federal loan interest payments due in July 1978 and January 1979, because SHA had a severe cash shortage. Such measures, however, could not save SHA. In October 1978, SHA began negotiating an agreement with Group Health Cooperative of Puget Sound for the purchase of SHA's assets, and in January 1979, the agreement was executed. It was estimated that about $260,000 would be available to cover SHA's $2.5 million Federal loan after other liabilities were paid. HEW revoked SHA's qualification in March 1979.

1/We made a similar observation in our June 1978 report based on our evaluation of 14 HMOs.

As shown in chart B, SHA's monthly costs per member became relatively constant at about $35 after the first quarter of 1977, when SHA had about 8,000 members. Based on the experience of HMOs we evaluated, membership growth alone could not be expected to further decrease current costs per member significantly. However, in July 1977 SHA projected that it would need almost 23,000 members to break even in late 1979.

SHA actually increased its membership from about 8,000 in March 1977 to about 12,600 in August 1978. But because costs per member had become relatively level, membership growth tended to increase SHA's cumulative losses.

After SHA's costs per member became relatively constant, at about $35 per month, SHA's main requirement for breaking even was to increase subscriber rates enough to generate sufficient revenues per member to cover costs. Its revenues, however, peaked at about $30 per month. We believe the major reason that SHA's monthly revenues per member peaked at about $30 was SHA's desire to be competitive in the market for new members, but competitive rates could not produce enough revenues to cover costs per member.

In a newsletter to its members in late 1978, SHA informed its members about the proposed sale to Group Health Cooperative of Puget Sound and stated:

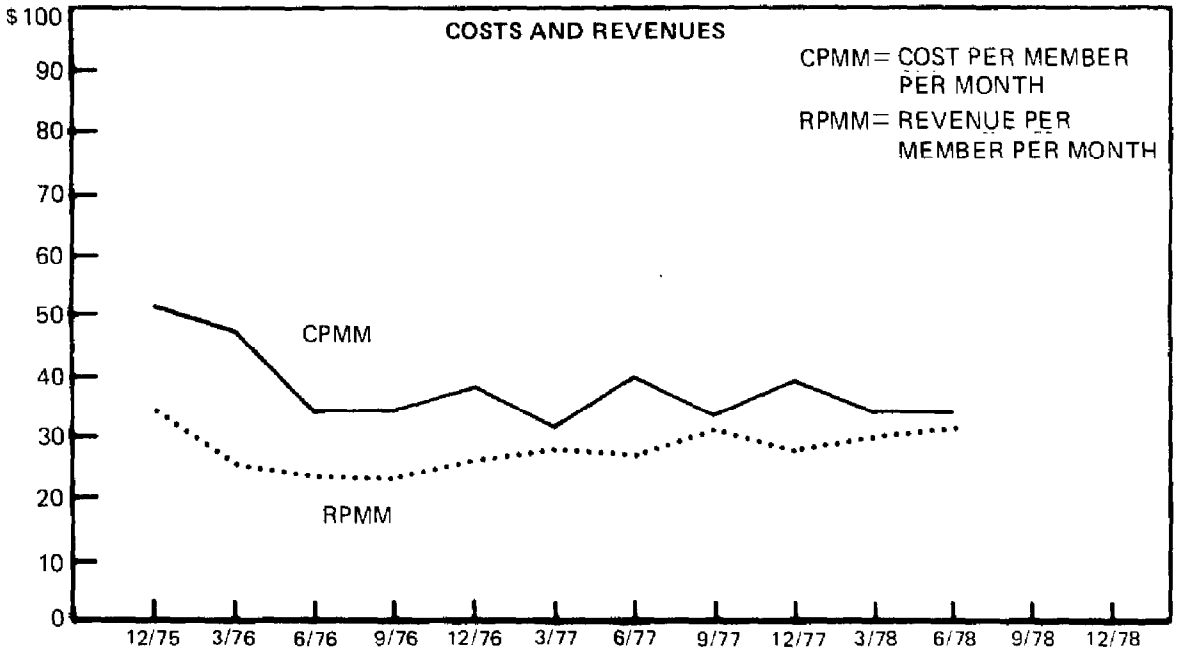
> " * * * federal qualification also mandated a level of benefits and services that were very costly to SHA during its start-up years; and which necessitated a level of dues that were often substantially higher than premiums charged by traditional insurers for health care programs with lesser coverage."

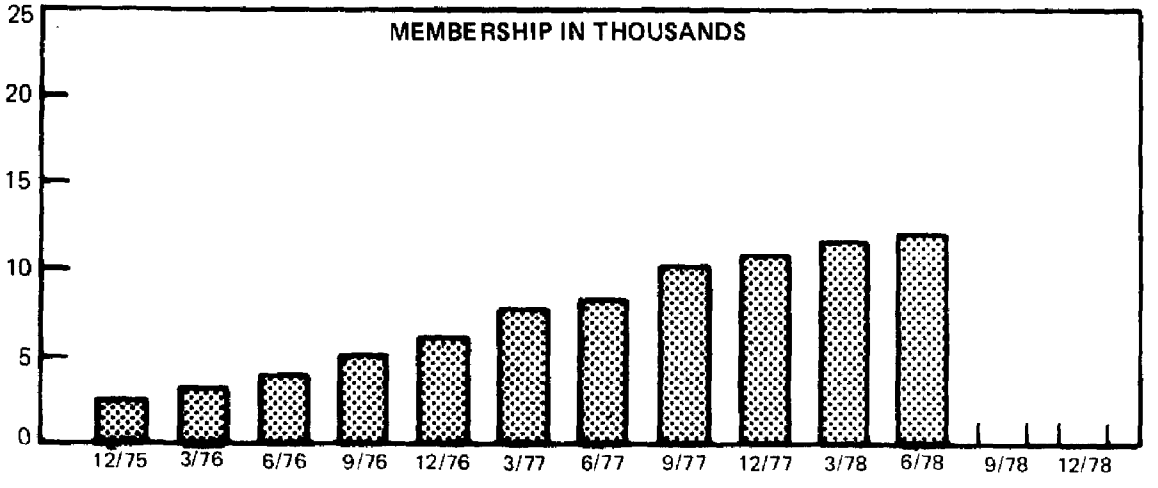
If SHA had raised subscriber rates enough to cover costs per member, it might have found that it could maintain a membership level of 8,000 to 10,000 at the higher rates but could not capture an increasing share of the market. This would have indicated that only a relatively small segment of SHA's potential market was willing to pay substantially higher premiums for SHA's coverage even though it was more comprehensive than competitors' plans.

CHART B

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF SOUND HEALTH ASSOCIATION (SHA)

(note a)





a/ COST, REVENUE, AND MEMBERSHIP DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1496).

Health Alliance of Northern California (HANC)

HANC became qualified in late 1976 and obtained a Federal loan of $2.342 million. By July 1978, it had incurred operating losses of over $2.4 million. Earlier, in March 1978, the State of California issued a cease and desist order, directing HANC to suspend marketing activities because it had failed to meet certain State financial and reporting requirements.

Because HANC had not complied with HEW's requirement for quarterly reporting of financial data, OHMO was unaware of HANC's serious financial problems. As late as August 1978, OHMO believed that HANC had reached break even in April 1978. In an August 3, 1978, letter the director of OHMO urged the State to retract its cease and desist order. However, on August 8, OHMO learned that HANC actually had incurred a large deficit of about $650,000 in the 3-month period May to July 1978. That same day the OHMO director wrote a letter asking the State to disregard his August 3 letter because HANC did not have enough Federal loan funds to cover the deficits and meet the State's net worth requirements.

In mid-September 1978, a State court appointed a receiver for HANC and authorized him to take appropriate action to protect the interests of HANC's creditors. The receiver did not negotiate a sale of HANC's assets but arranged a reorganization of HANC. Under the reorganization agreement, a local hospital agreed to lend $2 million to HANC to continue operating as a qualified HMO. HANC continues to exist as a separate legal entity responsible for its Federal loan, but the terms of the reorganization agreement required that the hospital assume the operation and management of HANC in mid-October 1978.

In our view, HANC's rapid financial decline was primarily a result of its desire to maintain competitive subscriber rates which were too low to cover costs, combined with explosive membership growth. HANC's primary competition was Kaiser Foundation Health Plan of Northern California. As of June 1976, Kaiser had about 18 percent of the health insurance market. Kaiser became a qualified HMO in October 1977. At that time, HANC's and Kaiser's subscriber rates were essentially comparable. HANC's revenues per member remained relatively constant from October 1976 through September 1977. We believe the desire to remain competitive with Kaiser may have influenced HANC to keep its subscriber rates at levels which proved to be too low to cover costs. Had HANC increased its subscriber rates enough to cover costs and found that it could

not increase its market share, this would have meant only a small market segment would pay rates that cover costs.

In a 14-month period from December 1976 through February 1978, HANC's enrollment increased from about 6,700 to about 21,700 members. However, as shown in chart C, HANC's monthly costs per member for the quarter ended December 1976 were about $29, which the experience of other HMOs indicates is the approximate level at which HMOs' current costs per member month cease to decline.

The quarter ended September 1977 was the last time HANC submitted required quarterly financial reports to HEW. For that quarter, HANC had about a $5 gap between monthly costs and revenues per member. Assuming that this gap persisted into 1978, HANC's large increases in membership tended to consume its Federal loan funds more rapidly because adding new members tended to increase its total deficit.

Some HMOs have characteristics similar to the two HMOs that became insolvent

As described earlier, we classified 10 HMOs as having a fair chance and 6 HMOs as having a poor chance to achieve financial independence, as required by the act. 1/ The financial experience of these HMOs raised some doubts about their financial soundness. As of late 1978, a few of the HMOs had not yet enrolled enough members for their monthly costs per member to become level. In our view, uncertainty about their ability to enroll members, coupled with their low level of revenues per member, raised serious questions about their financial soundness.

However, most of the HMOs had already enrolled enough members for their costs-per-member curves to become level. The problems faced by these HMOs were not identical, but as a group their problems included the following.

--Use of medical services had not been controlled adequately.

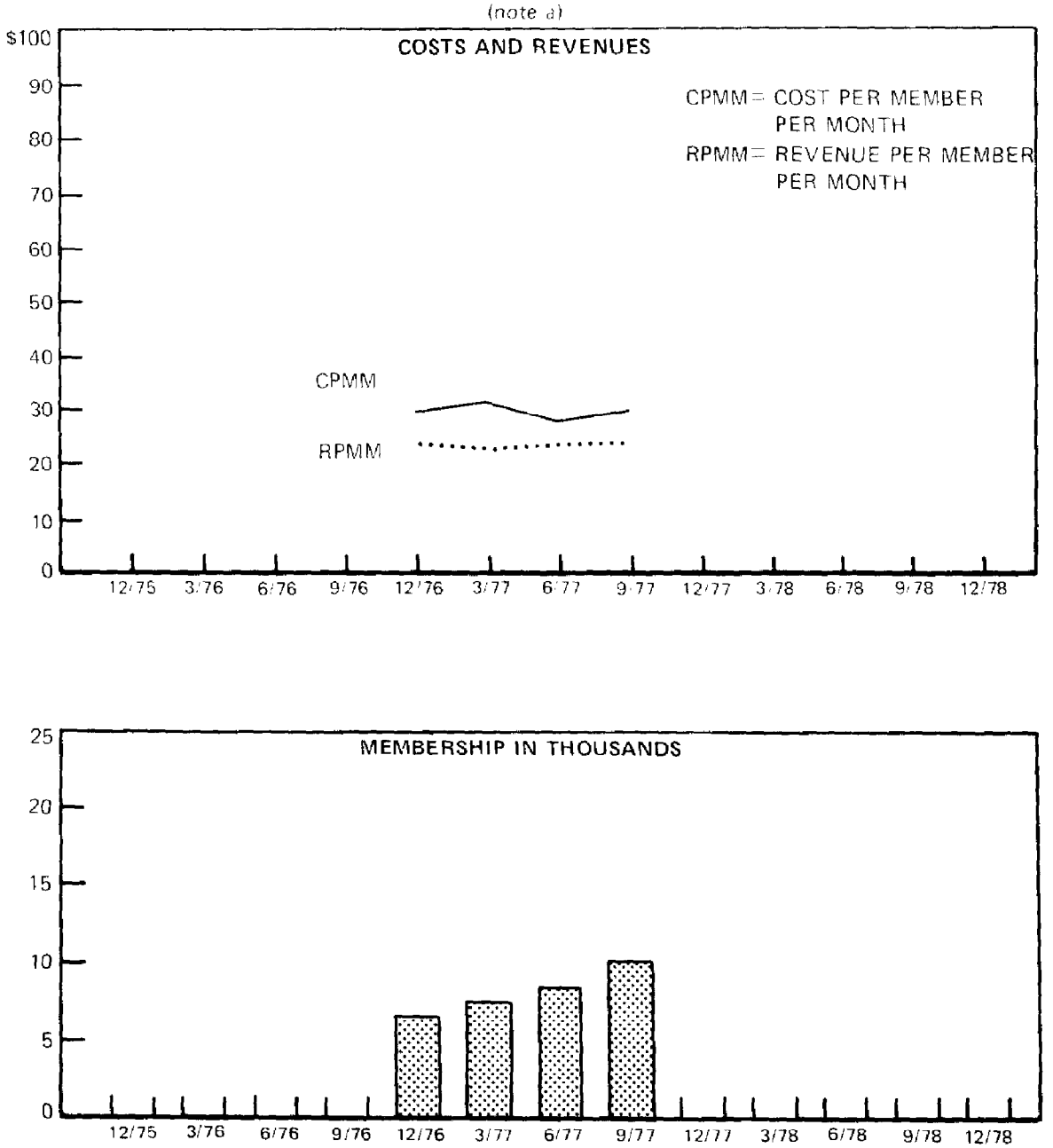
--Current costs per member had leveled, or appeared to be leveling, and revenues per member were significantly less than costs per member.

1/The operating experience of these HMOs is depicted in app. V, except for the two HMOs depicted on pp. 17 and 20.

CHART C

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HEALTH ALLIANCE OF NORTHERN CALIFORNIA (HANC)

(note a)



a/ COST, REVENUE, AND MEMBERSHIP DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1496)

--Some HMOs' subscriber rates were significantly higher than competitors' rates.

--Some HMOs had overemphasized the need to enroll new members, apparently without considering the impact on loan fund availability.

The following two cases illustrate the "poor" HMOs' problems, which were strikingly similar to the problems of the two HMOs that had become insolvent.

Case 1--An HMO with a poor chance to meet the act's financial soundness requirement

After analyzing the operating data the HMO submitted to HEW, we projected that it will need at least 5-1/2 years to break even. If the HMO were to break even by that time, we estimate that it would not need more than $4 million in loan assistance to cover its cumulative operating deficit. In our opinion, the HMO's financial problems resulted primarily from its failure to raise subscriber rates sufficiently during its early years of operation. As a result, the HMO shifted the burden of rate increases to the future and enlarged the size of needed increases in the latter part of its first 5 years of operation. As of December 1978, the HMO's revenues per member were about 12 percent less than cost per member. The HMO's ability to meet the act's financial soundness requirement now depends mainly on its ability to increase revenues per member enough to cover current costs per member, which have been relatively constant since early 1977. However, we greatly doubt the HMO's ability to raise subscriber rates significantly because, as of early 1979, its monthly family rates were as much as $20 to $40 higher than its competitors'.

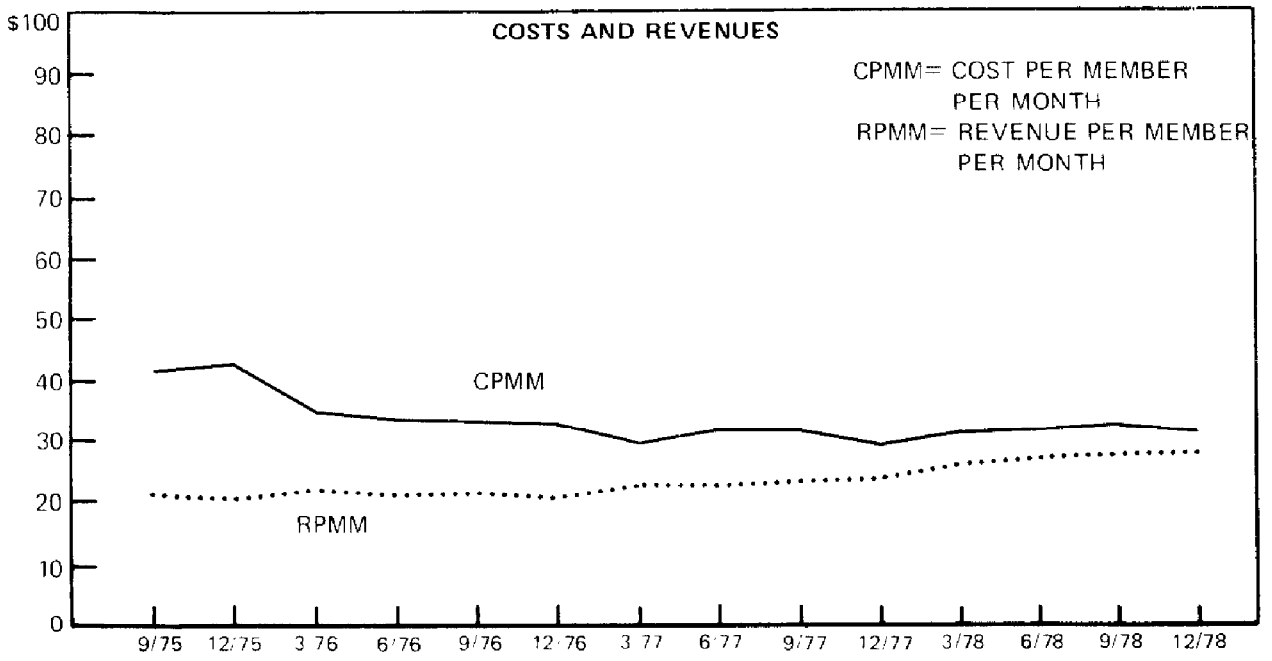
Qualified in mid-1975, the HMO has obtained total Federal loans of $2.5 million. However, by October 1978, the HMO had only about $30,000 remaining in its loan account. Its deficit for the quarter ended December 1978 was about $94,000.

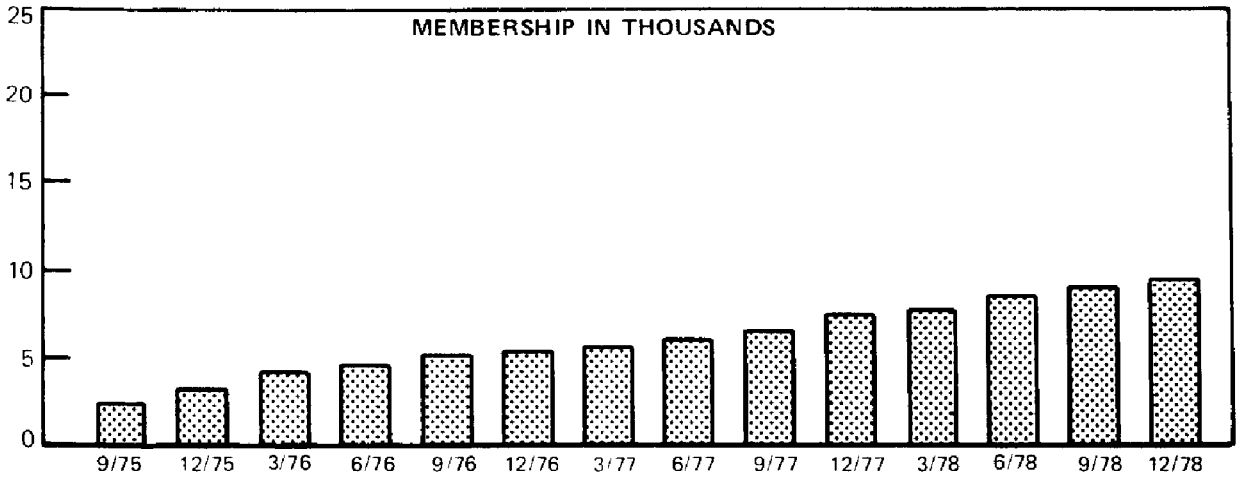
As shown in chart D, the HMO's monthly costs per member have been relatively constant since declining to about $30 in early 1977, when the HMO had about 5,800 members. In May 1977 HEW declared it to be in noncompliance with the act's financial soundness requirement, and the HMO prepared a corrective action plan. A cornerstone of the plan was a strategy for increasing membership to about 11,500 by the end of 1978.

CHART D

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF AN HMO WITH A POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(note a)





a/ COST, REVENUE, AND MEMBERSHIP DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1496)

The HMO actually increased its membership from about 5,500 in December 1976 to about 9,800 in December 1978, and its current costs per member remained relatively constant at about $30. The HMO's loss per member began to grow smaller after the HMO began raising its subscriber rates in early 1977. Before then, its revenues per member had remained virtually the same for 1-1/2 years. Although the difference between costs per member and revenues per member was decreasing, membership growth tended to increase the HMO's cumulative deficit and consume Federal loan funds at a faster pace.

Overemphasis on membership growth may give the HMO an incentive to attempt to hold subscriber rates at levels which are competitive but which will not cover costs per member. To survive, the HMO must raise subscriber rates enough to cover costs, repay debts, replace facilities, and finance future growth even if it means the HMO cannot capture an increasing share of the market.

Case 2--An HMO with a poor chance to meet the act's financial soundness requirement

After analyzing the operating data the HMO submitted to HEW, we projected that it may not be able to break even in 5 years and may need more than $4 million to cover operating losses. The HMO has had problems controlling utilization of medical services, but in our view, the main reason for the HMO's financial problems is that it has tried to maintain competitive subscriber rates that have been too low to generate revenues per member needed to cover costs per member. Although the HMO's revenues per member rose 56 percent during its first 2-1/2 years of operation, its revenues were still about 16 percent less than costs per member as of December 1978. The HMO's ability to further raise subscriber rates significantly is doubtful because, according to the OHMO loan branch chief, the HMO's monthly family rate was already as much as $20 higher than competitors' rates in February 1979.

Qualified in mid-1976, the HMO obtained a $1.475 million Federal loan. It later obtained a second loan of $1.025 million, giving the HMO total loans of $2.5 million. By September 30, 1978, the HMO had unexpended loan funds of only $299,000, but its quarterly deficits were still about $200,000. In February 1979, HEW loaned the HMO an additional $1 million.

Utilization control problems had been cited many times by HEW personnel. For example, in July 1977 an OHMO loan branch official reported that costs for referrals to outside

physicians and for hospitalization were excessively high compared with other HMOs and with the HMO's own projections. In December 1977 an OHMO management analyst reported that the HMO lacked control over referrals and hospitalization.

As shown in chart E, this HMO's monthly costs per member were at their lowest point, about $28, during the quarter ended September 1976--the HMO's first full quarter of operation as a qualified HMO. At that time, the HMO had about 6,200 members. The HMO has viewed continued membership growth as crucial to its ability to achieve financial independence. As of December 1976, the HMO's actual enrollment of 6,600 was about 5,100 less than projected. A major reason cited for the HMO's marketing failure was that its only health care facility was in an inner city area, which made marketing to surburban residents difficult.

Therefore, in April 1977 the HMO applied for an expansion grant to establish a second health care facility in order to enroll members at a faster rate. HEW approved the expansion grant in September 1977. Later in its December 1978 application for a third Federal loan, the HMO projected it would need about 23,000 members to break even by April 1980. As of February 1979, the HMO had only 14,100 members, which means the HMO must enroll about 9,000 new members during the next 14 months.

Such an ambitious enrollment goal may give the HMO an incentive to keep subscriber rates at levels which are competitive but which are too low to generate enough revenues per member to cover cost. This incentive to hold down subscriber rates will probably be very strong for the HMO because, as mentioned earlier, the HMO's monthly family rate was as much as $20 higher than competitors' rates in February 1979. The HMO must close the gap between costs and revenues per member, or it will only incur more losses as membership increases and use Federal loan funds more rapidly.

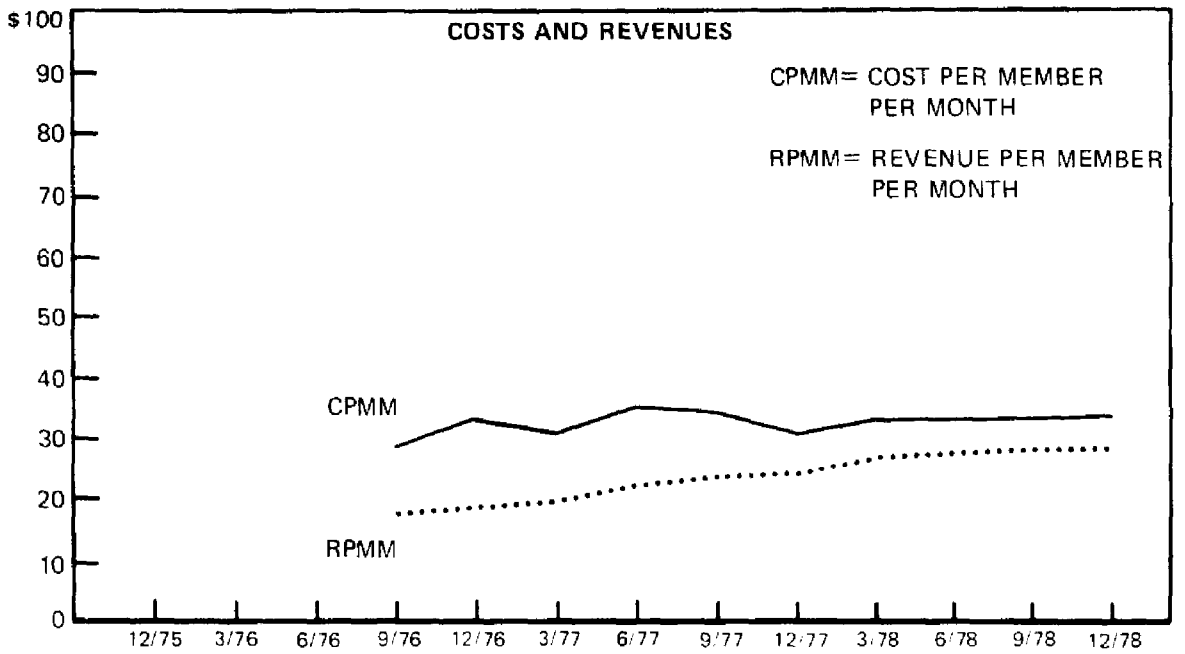
GOVERNMENT'S FINANCIAL RISK COULD BE MINIMIZED BY ESTABLISHING DECISION POINTS ON HMO VIABILITY

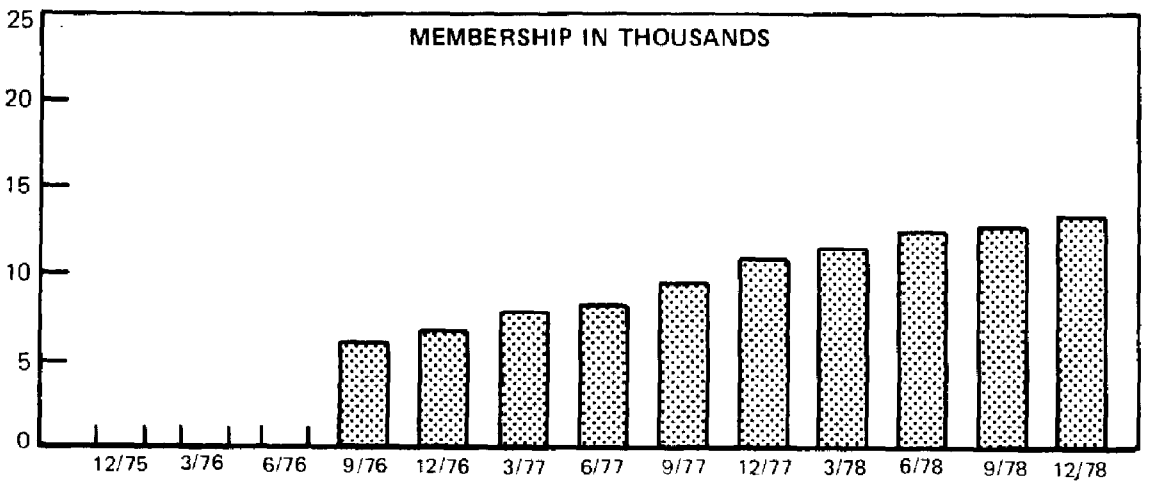
Under the HMO Act, HEW is responsible for protecting the Government's financial interests when loans are made to HMOs. We believe that HEW's experience with the two HMOs that became insolvent highlights HEW's responsibility to minimize the Government's risk.

CHART E

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF AN HMO WITH A POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(note a)





a/ COST, REVENUE, AND MEMBERSHIP DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1496).

After Sound Health Association was sold, it was estimated that only $260,000 would be available to cover its $2.5 million in Federal loans. Health Alliance of Northern California, on the other hand, did not default on its $2.342 million loan because a court-appointed receiver was able to reorganize its management and find additional financing which allowed it to continue operating. However, a memorandum prepared in December 1978 by an OHMO financial specialist stated:

> "* * * As has been seen from the experience of HANC and Sound Health, most investors are willing to purchase assets and put some additional amount representing 'goodwill.' Usually the offers have required forgiveness of federal loans and claims against assets obtained with grant funds. In other words, investors are not usually willing to pay for prior losses of a business regardless of the federal government's position in the deal."

We believe that the experience of the 42 HMOs we evaluated suggests that there are appropriate decision points at which an HMO's financial viability should be assessed. For example, one indication of the HMOs' experience is that HMO planners should not assume that progressively increasing enrollment will result in progressively lower costs per member in current dollars. As previously stated, we observed that the HMOs' costs per member month had become relatively stable by the time they had enrolled 10,000 members, but we recognize that this could vary somewhat based on such factors as type of HMO or geographical location. Further study by HEW could provide more definitive data on the occurrence of this phenomenon.

With such data HEW could encourage a new HMO to plan its initial stage of operation so that it will have only enough staff and facilities to enroll enough members for its costs per member month in current dollars to become relatively stable. The costs per member incurred at that point may provide a baseline for actuarially projecting an HMO's future costs per member, taking into account such factors as anticipated cost inflation, changes in enrollment mix, and the possibility of more effective cost and utilization controls.

After projecting future costs per member, OHMO should determine actuarially whether the subscriber rates which the HMO will need to achieve financial independence within

5 years after qualification will be competitive in the local market. Such a procedure could provide a method for assessing an HMO's ultimate financial viability before it has exhausted Federal loan funds. Thereby, this procedure would help minimize the Government's risk of losses through loan defaults.

HMO MANAGERS GENERALLY BELIEVE FEDERAL LOAN ASSISTANCE AVAILABLE UNDER THE ACT IS ADEQUATE

Deficit loans

Our questionnaire asked each respondent to estimate the amount of deficit loan assistance needed by an HMO of the same type and in the same area as the respondent. As shown on page 23, the 66 qualified HMOs responding to this question estimated that HMOs need an average amount of $2.9 million of loan assistance. Seventy-six percent of the respondents estimated that an HMO should need no more than $4 million.

Each respondent was also asked to estimate how many years are needed to achieve financial independence. The 64 qualified HMOs responded to this question estimated that HMOs need loan assistance for an average of 4.5 years. Ninety-one percent of the respondents estimated that an HMO should be able to operate without Federal financial assistance after no more than 5 years.

Ambulatory facility loans

The HMO Amendments of 1978 established a new program authorizing HEW to loan a qualified HMO up to $2.5 million to acquire or construct and equip an ambulatory (outpatient) health care center. The amendments did not limit the number of facilities for which an HMO can obtain such loans.

In our questionnaire, we asked each qualified HMO and each grantee that had applied for qualification whether they planned to apply for ambulatory health care facility loans. Of the 32 that said they planned to apply for such loans, 28 estimated the loan amounts they needed for a total of 48 planned facilities. They estimated they would need $2.5 million or less for 43 of the 48 facilities. As a result, we believe the act provides adequate loan assistance for acquiring or constructing and equipping ambulatory health care centers.

Amount of Loan Assistance Needed by HMOs--
Estimates by Managers Of Qualified HMOs and by HMO Grantees
in the Initial Development Stage

Qualification status	Estimate of deficit loan assistance that should be available to HMOs				Estimate of years HMOs need to achieve financial independence			
	Number of respondents	Mean	Median	Range	Number of respondents	Mean	Median	Range
		(millions)				(years)		
Qualified HMO	66	$2.9	$3.0	$ 0-$6.0	65	4.5	5.0	0-10
Applied for qualification	10	2.3	2.5	0.05- 5.0	10	4.3	4.0	3-6
In initial development stage but have not applied for qualification	18	1.9	2.0	0- 4.0	17	4.0	4.0	3-5
Total population	94	2.6	2.5	0- 6.0	92	4.4	4.6	0-10

CONCLUSIONS

We believe that (1) the HMO Act, as amended, provides for adequate loan assistance for HMOs to cover operating losses incurred during their first 5 years of operation, (2) it is reasonable to expect an HMO to operate without Federal financial assistance after 5 years of operation, and (3) the new loan program designed to help HMOs acquire or construct and equip ambulatory health care facilities provides for adequate loan assistance.

HMOs which can control costs efficiently should find they can break even within 5 years and with cumulative losses of $4 million or less, provided they charge subscriber rates that are high enough to produce revenues per member that cover costs per member.

Similar to most competitive enterprises, HMOs face conflicting goals: they must set prices high enough to recover costs, repay debts, replace facilities, and finance future growth; yet, they must set prices low enough to be competitive in the marketplace. If an HMO emphasizes capturing a progressively increasing share of the market, it will strive to maintain highly competitive prices. However, because an HMO must offer benefits that are generally more comprehensive than its competitors' benefits packages, the HMO may find that competitive prices are too low to generate enough revenues per member to cover costs per member. In such a case, an HMO would continue to incur deficits no matter how many members it enrolls or how well it manages and controls utilization and costs of operation.

We observed that the current costs per member month of the HMOs we evaluated generally declined sharply as enrollment increased, but the rate of decline began to decrease until it neared zero and current costs per member became relatively stable. We observed that the HMOs' current costs per member usually became relatively stable by the time they had enrolled 10,000 members. In some cases their costs per member had begun to increase.

We believe that the point at which an HMO's costs per member month stop declining would be an appropriate time to assess the HMO's ultimate financial viability. At that point, the HMO's costs per member could provide a reasonable baseline for actuarially projecting the HMO's future costs per member and assessing the competitiveness of subscriber rates needed to assure the HMO's financial success.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW establish a development strategy which guides new HMOs to plan for only enough staff and facilities to enroll and serve enough members during the initial stage of operation for the HMO's current costs per member month to become relatively stable. We observed that current costs per member month of HMOs we evaluated generally had become relatively stable by the time they enrolled 10,000 members. In some cases, their costs per member month had leveled and begun to increase. HEW should further study this phenomenon to develop more definitive data.

The point at which an HMO's costs per member month become relatively stable could provide a baseline for actuarially projecting the HMO's future costs per member. After future costs per member are projected, HEW could actuarially assess whether the subscriber rates which the HMO would need to achieve financial independence would be competitive. This procedure could provide a point at which HEW could assess the HMO's ultimate financial viability before the HMO's Federal loan funds are exhausted. Such an assessment could provide guidance to HEW and the HMO on the enrollment growth patterns most likely to result in financial independence.

AGENCY COMMENTS AND OUR EVALUATION

In a draft of this report furnished to HEW for comment, our proposal for a development strategy for loans to new HMOs suggested that initial loans be based on expected operating

deficits that would be incurred until the HMO reached an enrollment level of 8,000 to 10,000 members--the point at which we observed that costs per member month became relatively constant. In commenting on our report, HEW expressed the view that its HMO development strategy and its assessments of financial viability should not focus strongly on our observation that the costs per member month of the HMOs we evaluated tended to cease declining by the time they had enrolled 10,000 members. HEW pointed out that our analysis had not considered inflation and that the sample size was small.

However, HEW stated that it found our analysis informative and useful. HEW added that our analysis would provide a benchmark to identify HMOs with potential financial problems and to begin focusing on the use of revenues when an HMO's costs per member first begin to level off. At that time, HEW plans to make a more indepth financial analysis and, if necessary, take corrective action.

After evaluating HEW's comments, we modified the recommendation in the report concerning a development strategy for new HMOs to emphasize cost stability rather than enrollment size. We believe that HEW's plans and comments meet the intent of our recommendation, and we encourage HEW to do further study in this area to develop more fully this tool for assessing HMO financial viability and minimizing the Government's financial risk.

CHAPTER 3

LOAN PROGRAM ADMINISTRATION: IMPROVEMENTS HAVE BEEN MADE BUT FURTHER STRENGTHENING IS NEEDED

In our September 1976 and June 1978 reports (see note, p. 1), we pointed out that HEW had not issued formal policies needed to assure uniform administration of the operating deficit loan program. In our June 1978 report, we noted that the OHMO Loan Branch did not have enough staff to review loan applications. By March 1, 1979, OHMO had drafted formal policies for the deficit loan program and had begun drafting regulations and policy guidance for the new ambulatory health care facility loan program. OHMO also had increased the size of the Loan Branch staff. However, the target dates for issuing loan policies remain uncertain, and the Loan Branch may soon need additional staff.

OHMO's Compliance Division, established as a distinct organizational entity during fiscal year 1978, is responsible for monitoring the operations and financial viability of qualified HMOs. In June 1978, we reported that OHMO had not issued compliance regulations and did not have enough staff to monitor systematically the financial soundness of HMOs with loans. As of March 1, 1979, OHMO had improved the compliance program. However, some problems persist that may prevent the Compliance Division from functioning as effectively as anticipated.

LOAN PROGRAM POLICIES AND REGULATIONS STILL MUST BE ISSUED

Although progress had been made toward finalizing operating deficit loan policies and formulating regulations and policy guidance for the ambulatory health care facility loan program, it is still not clear when the regulations and policies will be issued. Specifically

--OHMO's schedule for issuing formal operating deficit loan policies has slipped significantly and

--OHMO's target dates for issuing regulations and policy guidance on the new ambulatory health care facility loan program are optimistic.

Formal policies for the deficit loan program remain unissued

In commenting on our June 1978 report, OHMO said that the Public Health Service loan policy officer was reviewing HMO program loan policies and that this review would be expedited to permit early implementation. In October 1978, OHMO's Division of Development set June 30, 1979, as the target date for issuing operating deficit loan policies. However, as of March 1, 1979, the division had fallen behind schedule to such an extent that the target date probably cannot be met.

The Division of Development has drafted a series of operating deficit loan policies pertaining to (1) loan monitoring, defaults and remedies, and general provisions applying to direct loans and loan guarantees, (2) special provisions applying to direct loans only, and (3) special provisions applying to loan guarantees only. The Public Health Service loan policy officer has reviewed the drafts, but because of insufficient staff, the division has redrafted only the general provisions, loan monitoring, and defaults and remedies sections for further review by the loan policy officer and HEW's Office of General Counsel.

The division's October 1978 workplan schedule for issuing operating deficit loan policies has slipped considerably. For example, certain parts of the general provisions section were to be issued between November 1978 and February 1979; loan monitoring policies were to be completed by December 1, 1978; and defaults and remedies policies were to be completed by January 7, 1979. As of April 1, 1979, none of these sections had been issued, but publication was expected around May 1.

Considering the slippage that occurred while preparing the first three sections for issuance, the two remaining sections--special provisions applying to direct loans and loan guarantees--probably will not be completed by June 30 as planned. The Loan Branch chief was able to assign only one part-time staff member to preparing all of the operating deficit loan policies because of the loan application workload. Although the two remaining sections are considered to be relatively small, the branch chief agreed that, given staffing limitations and the lengthy review process, the June 30 target date is unrealistic. He estimated that the remaining policy sections will not be completed before the end of fiscal year 1979.

ew authority permit-
ion to acquire or con-
care facility. OHMO
guidance for the loan
lan prepared in February
March 30, 1979, as the
ence and publishing
gister" for public com-
ted about getting ambula-
informed them that
lations are published.
was scheduled for
as already failed to

deadline for issuing
interim regulations
. By April 1 the reg-
had slipped about
uled to be submitted
comment by February 20,
minimal policy guidance
plan indicated comple-
employee responsible
estimated that the reg-
General Counsel by about
date when the policy
explaining that this de-
ral Counsel reviewed
would have to be re-
during some of the review
the pro is still more. Given the
and the likelihood of addi-
will not be able to
needed to set the ambu-
in motion by July 31,

pplications for ambula-
be received once poli-
he OHMO Loan Branch may

soon face staffing shortages. According to the chief, the branch is adequately staffed to handle its fiscal year 1979 deficit loan application workload but does not have enough staff to handle the increased number of loan applications that are expected once the ambulatory health care facility loan program gets underway.

The Loan Branch's staffing situation has improved in the last year. In mid-February 1978, the branch had only two staff members to review loan applications and prepare loan award documents. By March 1, 1979, the staff had been increased to five permanent, full-time members--one loan officer and four program analysts. 1/ At that time the branch was processing 15 loan applications--13 for new loans and 2 for supplemental loans. In addition, the branch was processing three requests for accelerated drawdowns on existing loans. OHMO projected that the Loan Branch would approve 25 operating deficit loans in fiscal year 1979.

The branch chief stated that his staff was large enough to handle the fiscal year 1979 loan application workload, provided that the Qualification Division, Compliance Division, and regional offices carried out certain key responsibilities. For example, in the past, staff responsible for qualifying HMOs and awarding loans both made determinations about an HMO's financial viability. Now the Qualification Division is responsible for making this judgment, while the Loan Branch focuses on technical issues involved in making loans.

In the same vein, the Compliance Division is now formally responsible for monitoring the continuing financial viability of HMOs with Federal loans. The Loan Branch is now directly responsible only for assuring that HMOs comply with the technical requirements of loan agreements. This responsibility, in turn, has been delegated to the regional offices. As of March 1, 1979, however, the regional offices had not begun monitoring, and although the branch chief expected them to start soon, he was unable to provide a precise date.

As of mid-February 1979, OHMO had not formally estimated the workload expected to result from the new ambulatory health care facility loan program. The director of the Division of

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1/One program analyst was spending about 75 percent of his time preparing regulations and policy guidance for the ambulatory health care facility loan program.

Development and the Loan Branch chief informally surveyed qualified HMOs and estimated that about 25 loan applications would result. Since OHMO will apparently be unable to start the program much before the end of fiscal year 1979, these applications will become part of the Loan Branch's fiscal year 1980 workload. Assuming that the branch's operating deficit loan workload for fiscal year 1980 will be the same as the fiscal year 1979 workload of 25 applications, the 25 additional ambulatory health care facility loan applications would double the branch's overall workload.

Based on our questionnaire results, interest in the new loan program may be even greater. We asked managers of qualified HMOs and grantees that have applied for qualification whether they anticipated applying for a loan to acquire or construct and equip an ambulatory health care facility within the 2-year period January 1979 to January 1981. Of the 76 who responded, 32 (about 42 percent) said that they expected to apply. These 32 respondents indicated an interest in setting up a total of 54 facilities. Since a separate loan application will be required for each facility planned, the 32 respondents would generate a total of 54 loan applications. Although the respondents were asked to estimate their need for ambulatory health care facility loans over a 2-year period ending January 1981, the Loan Branch's fiscal year 1980 workload will be most affected if the program does not begin until the start of fiscal year 1980. Adding 54 ambulatory facility loan applications to 25 operating deficit loan applications would more than triple the branch's workload.

The Loan Branch chief stated that the branch is not staffed adequately to handle the significant workload increase expected once the ambulatory health care facility loan program gets underway. Although leadtime is needed to bring a new staff member up to full efficiency, he was also not aware of any plans to increase the branch's staff in anticipation of a workload increase. According to the director of the Division of Development, there are no plans to increase Loan Branch staffing in fiscal year 1979.

The fiscal year 1980 appropriation request includes nine additional personnel positions for the division, of which the Loan Branch is a part. However, no decision has been made about how the positions might be distributed. Furthermore, even if the Loan Branch were to receive some of these positions, the division director does not anticipate filling them before the spring of 1980 because she presumes there will be some delay in receiving the appropriation. Therefore, if

the ambulatory health care facility loan program starts anytime before the middle of fiscal year 1980, the Loan Branch may be inadequately staffed to handle it.

ADDITIONAL ACTION IS NEEDED TO ASSURE EFFECTIVE MONITORING OF HMOs WITH FEDERAL LOANS

In guidance issued to the regions in August 1978, developing and implementing an effective compliance system was listed as one of three major activities OHMO planned for fiscal year 1979. As of March 1, 1979, OHMO had improved the compliance program by (1) issuing compliance regulations, (2) publishing an HMO compliance plan, which outlined the compliance program's functions, procedures, organization, and staffing, and (3) developing a computerized management information system to summarize performance data on HMOs and provide the basis for an "early warning" system that would, among other things, monitor the financial soundness of HMOs. Also, the Compliance Division's staff had been greatly expanded.

In assessing the division's plan to monitor the financial viability of qualified HMOs, we found problems that may prevent the division from doing its job as effectively as anticipated. Specifically:

--Some HMOs do not submit the quarterly reports containing the data the division needs to effectively monitor compliance in a timely fashion.

--The data the division receives may not be reliable.

--Staffing in the HMO Compliance Branch, although significantly increased, still may not be adequate to handle an increasing workload.

--OHMO lacks uniform policy guidance by which to evaluate compliance.

--OHMO has not defined the regional compliance role.

Many HMOs do not submit required reports to OHMO in a timely fashion

The HMO Compliance Branch, part of OHMO's Division of Compliance, is responsible for assuring that qualified HMOs comply with all aspects of the act. Financial unsoundness has been the most common and serious problem among HMOs in trouble. To monitor financial viability, the branch will rely heavily on OHMO's new early warning system, which is based on data contained in quarterly reports HMOs are required to submit to OHMO. The system's purpose is to identify problems early enough to generate corrective action, and its success depends largely on the prompt submission of quarterly reports. However, many HMOs do not submit these reports promptly.

OHMO expected reports from 53 HMOs for the third quarter of calendar year 1978. As of December 12, 1978, about a month after the reports were due, 19 (about 36 percent) of the HMOs had not responded. On January 19, 1979, OHMO still did not have the third quarter reports of five HMOs. For the fourth quarter, OHMO expected reports from 60 HMOs. Reports were due on February 15, 1979, or March 15, 1979, if the quarter also marked the end of an HMO's fiscal year. As of March 27, 1979, 33 (about 55 percent) of the HMOs had not responded.

In December 1978, the Division of Compliance initiated a "tickler" system to encourage the prompt submission of quarterly reports. Under the system the division's document control officer is responsible for sending polite reminders to HMOs that are a week late submitting their reports. After about 2 weeks, a stronger reminder is sent. These letters state that, if the reports are not submitted within 15 days of their receipt, OHMO will issue a notice of noncompliance and a notice of intent to default on a loan, if applicable.

According to the document control officer, HMOs have responded to the reminders. However, she is sometimes unable to get the notices out as promptly as desired because of her workload. Since the tickler system already permits a grace period of about 5 weeks before OHMO takes serious action, additional delays could make its value questionable.

The early warning system may lack reliable data

To be effective, the early warning system requires reports that are not only timely, but also accurate. However, questions have been raised about the reliability of the

data HMOs submit in these reports. One compliance officer, for example, expressed concern about the effectiveness of the early warning system because she felt the data in quarterly reports were poor. One of the analysts who helped develop the early warning system agreed that the data were not very good.

OHMO has not validated the accuracy of data HMOs submit in quarterly reports. Recognizing the importance of good data to the early warning system's success, the Division of Compliance included a step in its January 1979 workplan to design and implement procedures for validating quarterly report information. According to the division director, computer programs were to be developed that would compare, among other things, an HMO's quarterly reports to its yearly audited financial statements to determine accuracy of reported data. The workplan target date for completing the step was February 1; however, as of March 1, validation procedures were still being designed and tested.

Staffing in the HMO Compliance Branch may not be sufficient to handle an increasing workload

The workload for each HMO compliance officer has exceeded early projections. When staffing levels were first considered, it was anticipated that each compliance officer would monitor eight HMOs. The HMO Compliance Branch has 10 compliance officers. As of March 23, 1979, there were 89 qualified HMOs, or an average of about 9 HMOs per compliance officer, and the workload is expected to grow. OHMO projects a total of 116 qualified HMOs by the end of fiscal year 1979 and 144 by the end of fiscal year 1980. This would mean that each compliance officer will be responsible for monitoring 11 HMOs in fiscal year 1979 and 14 HMOs in fiscal year 1980.

The Division of Compliance has not determined how many HMOs a compliance officer can monitor effectively. It appears, however, that 10 may be the maximum manageable workload, provided that the HMOs are not experiencing serious financial problems. According to compliance officers we interviewed, monitoring 10 is manageable, although one officer believed that only one site visit per year would be possible. They also added that, if two or three HMOs had financial problems requiring considerable attention, an officer could not adequately monitor the other seven or eight.

As of April 1, 1979, seven HMOs had received notices of evaluation, indicating that serious problems might exist, and five had received notices of noncompliance, indicating that serious problems had been confirmed. Financial viability was a concern in each case. To prevent overburdening a compliance officer who is handling two or three problem HMOs, the division distributes his remaining workload among other compliance officers. However, since the compliance officers are already handling an average of about nine HMOs apiece, giving them responsibility for even more HMOs may impair their ability to do their jobs adequately. Similarly, as the number of qualified HMOs grows, staffing in the HMO Compliance Branch may not be sufficient to handle the increasing workload.

According to the director, Division of Compliance, the early warning system, when fully operational, should enable compliance officers to adequately monitor more HMOs. The system will give compliance officers summaries of performance data on the HMOs they are monitoring and flag HMOs with problems. The system will also provide key information about the causes of problems, and financial and marketing specialists will be available to help compliance officers analyze data. If the system operates properly, it might help compliance officers handle a larger workload. However, given the data problems described in preceding sections (see pp. 32 and 33) and the fact that the system is still untried, it is premature to assume that this will occur.

OHMO lacks uniform policy guidance by which to evaluate HMO compliance

The director of the Division of Compliance stated that his efforts to improve the compliance program have been impaired somewhat by the lack of uniform policy guidance throughout OHMO concerning such important issues as determining financial viability. New compliance officers have not received a policy manual outlining OHMO's position on situations they must evaluate. Consequently, the division's January 1979 workplan included a step to begin compiling a compliance policy and procedures manual by February 1.

The policy section of the manual is intended to be officewide in scope. According to the division director, to develop the policy section the division assembled Office of General Counsel decisions, qualification denial letters, program bulletins, and other documents containing OHMO policy

statements. By early March, 1979, the manual had been outlined and Division of Compliance administrative policies had been summarized. The director estimated that the compliance procedures section of the manual would probably be completed by the end of fiscal year 1979. However, the policy section would be finished only if agreement could be reached on all OHMO policies. The director was less confident about completing the policy section by the end of fiscal year 1979 because of expected delays in reaching full agreement on some issues.

OHMO has not defined the regional office compliance role

In its August 1978 guidance to the regional offices, OHMO stated that protocols outlining regional office compliance responsibilities would be prepared in the next few months. Also, OHMO indicated that consideration was being given to assigning some compliance officers to the regional offices because of the likelihood that more accurate information could be obtained there than at OHMO headquarters. However, by early March no decisions had been made about the regional office compliance role.

Based on our review work at three regional offices, it appears that regional personnel may be in a better position than headquarters staff to monitor some compliance aspects. In some instances regional personnel were able to identify an HMO's difficulties before headquarters staff became aware of them. For example, in one case regional personnel learned from State agency contacts about a drastic increase in an HMO's enrollment during one month. They immediately visited the HMO and found that the increase was causing excessive referrals that could have resulted in health care cost increases. Generally, regional personnel are closer to HMOs, have detailed knowledge about the HMOs in their regions, and can more easily establish personal contacts with HMO personnel and State regulatory officials.

In the view of the director, Division of Compliance, before a regional office compliance role is finally defined, the headquarters compliance operation should be functioning smoothly. Policy and procedures should be clearly delineated, and the early warning system should be fully operational. Also, specific guidance on the compliance process and required procedures should be available for the regional office staff. In light of these criteria, the director did not think OHMO was ready to define a regional office compliance role.

We recognize that policies and procedures are needed before the regional role can be defined, but because of the potential advantages a regional compliance role offers, we believe OHMO should complete the necessary policies and procedures as quickly as possible.

CONCLUSIONS

HEW has made progress toward publishing formal, uniform operating deficit loan policies; formulating and issuing regulations and policy guidance for the ambulatory health care facility loan program; and improving the Loan Branch's staffing situation. However, some problems persist.

As of April 1, 1979, the operating deficit loan policies had not been issued, and they were not likely to be published in their entirety by the June 30, 1979, target date. Similarly, preparation of regulations and policy guidance for the ambulatory health care facility loan program had begun to fall behind schedule, and more delays were anticipated at various review stages. Sufficient staff and priority need to be assigned to these projects so that uniform policies for awarding operating deficit loans can be available as soon as possible and the ambulatory health care facility loan program can get underway.

Although the Loan Branch appears to be adequately staffed to handle its projected workload for fiscal year 1979, it may be understaffed to handle the larger workload expected to result in fiscal year 1980 from the ambulatory health care facility loan program. Early attention needs to be given to the effects of the new loan program on the branch's workload so that timely, informed decisions can be made about the need for more staff.

HEW has improved its compliance program, and more changes are in progress. Although it is still too soon to determine the effectiveness of OHMO's new compliance effort, we perceive some problems that could impair the effort's success.

Data required for the early warning system are not being submitted in a timely fashion, and there are questions about their reliability. The new tickler system for reminding tardy HMOs to submit their reports should be carefully watched to determine its effectiveness, and consideration

should be given to assigning more staff to operate it. Also, priority should be given to developing and implementing procedures for validating report data as soon as possible. Staffing in the HMO Compliance Branch may not be sufficient to handle a larger workload. Constant attention should be paid to the staffing needs in the branch so that the new compliance program is not crippled at the start by a staff shortage. Further, priority should be placed on completing a compliance policy and procedures manual and defining regional compliance responsibilities.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW:

--Assign enough staff to complete work on policies for the deficit loan program and regulations and policies for the ambulatory health care facility loan program and see that these regulations and policies move quickly through departmental review levels.

--Assess the impact of the ambulatory health care facility loan program on the workload of OHMO's Loan Branch to assure that the branch is adequately staffed when the new loan program begins.

--Take action needed to assure that required reports from qualified HMOs are submitted more promptly.

--Assess the impact of an increasing number of qualified HMOs on the HMO Compliance Branch's ability to monitor their compliance so that additional staff can be assigned promptly, if required.

--Give priority to validating HMO report data, completing a summary of compliance policy and procedures in order to assure uniformity, and rendering a decision on regional responsibilities.

AGENCY COMMENTS

HEW concurred in our recommendations, stating, among other things, that (1) priority is being given to completing needed loan regulations, policies, and procedures promptly, (2) of the nine positions requested for OHMO programs in

fiscal year 1980, three are targeted for the Loan Branch, (3) an effort will be undertaken to quantitatively measure the impact of OHMO's new monitoring process and computer system on staff efficiency, and (4) a structured OHMO policy and procedures manual can be expected within 9 months and a final decision about the future regional office role by the end of the fiscal year.

CHAPTER 4

HMO ACT PROVIDES FOR ADEQUATE GRANT ASSISTANCE BUT FISCAL YEAR 1979 BUDGET UNCERTAINTIES MAY AFFECT PROGRAM IN LATER YEARS

The HMO Act, as amended, provides for grants to public or nonprofit organizations to help fund the costs of feasibility studies, planning, and initial development activities needed to establish a new HMO or to expand the operations of a qualified HMO. The results of our questionnaire indicated that the act generally provides for adequate assistance to grantees.

However, because the fiscal year 1979 budget for the grant program is uncertain, OHMO may have to fund a limited number of grants in that year which could decrease the number of grantees becoming ready for qualification in later years.

QUESTIONNAIRE RESULTS INDICATE THE ACT PROVIDES FOR ADEQUATE GRANT ASSISTANCE

New HMOs are developed through a three-phase grant process. First, grantees must determine whether an HMO is feasible in their area. Feasibility studies include such activities as identifying target population groups and potential providers; estimating subscriber and facility requirements; and identifying State laws, regulations, and practices relating to HMOs.

After a grantee establishes that an HMO is feasible, the grantee must perform planning activities, which include such things as recruiting key staff; establishing community support; developing a formal organization, health benefits plan, premium structure, marketing plan, and financial plan; identifying basic health services providers; and planning for necessary facilities and equipment.

Once plans are made, the grantee is ready to begin the initial development activities necessary to prepare for operations as a qualified HMO. Initial development activities include such things as recruiting and training essential personnel, developing a comprehensive financial plan, organizing physicians and other basic health services, constructing or renovating facilities, organizing ambulatory care facilities, and initiating an enrollment plan.

The amounts provided for by the act to help grantees through these three phases are summarized below.

Grant Amounts Available Under
The HMO Act, As Amended

Type of grant	Maximum number of grants	Maximum amount of each grant (note a)	Total amount available	Maximum period of each grant
Feasibility	[illegible]	b/$ 75,000	$ 150,000	1 year
Planning	[illegible]	c/200,000	400,000	1 year
Initial development	(d)	e/1,000,000	e/1,000,000	f/3 years
			$1,550,000	

a/Grantees who receive less than the maximum allowable grant award may apply for a supplemental grant to complete the project.

b/The HMO Amendments of 1976 increased the ceiling from $50,000 to $75,000.

c/The HMO Amendments of 1976 increased the ceiling from $125,000 to $200,000.

d/No number is specified by the act, as amended.

e/The HMO Amendments of 1978 will increase the ceiling to $2 million on October 1, 1979.

f/Total time for initial development is not to exceed 3 years.

Based on the results of our questionnaire, we believe the ceilings placed on grants for HMO feasibility studies, planning, and initial development are reasonable and do not need to be increased.

Feasibility grants

Seventy-six respondents to our questionnaire had received at least one feasibility grant during fiscal years 1975-78 to establish a new HMO; only six had obtained two

feasibility grants. The average amount of their first feasibility grants, including supplemental amounts, was about $62,000. However, as shown below, the average amount for each fiscal year had increased from about $49,000 in 1975 to about $71,000 in 1978.

Amounts Of First Feasibility Grants Awarded To Establish New HMOs (note a)

Fiscal year	Number of respondents	Mean amount	Median amount	Range
1978	44	$70,942	$72,344	$42,455-$75,000
1977 (note b)	-	-	-	-
1976	5	46,745	49,838	30,000-57,793
1975	27	49,334	49,927	45,000-50,000
Total	76	61,673	67,160	30,000-75,000

a/Includes supplemental grant amounts.

b/OHMO awarded only five feasibility grants in fiscal year 1977. None of the respondents to our questionnaire received its first feasibility grant in that fiscal year. The average amount of the five grants awarded in 1977 was $41,737.

Of the 76 respondents, 51 said they had completed their feasibility studies, and only 2 said the outcome of their studies had been inadequate. Neither attributed the inadequacy to lack of funds.

All respondents to our questionnaire were asked to estimate at today's prices the cost of doing a feasibility study to establish a new HMO. Of 143 who responded to this question, 42 percent estimated it would cost $75,000 or less, 80 percent estimated $100,000 or less, and 94 percent estimated $150,000 or less. The average estimate was about $98,000. The maximum amount available to a grantee is $150,000.

We asked each qualified HMO and each grantee that had applied for qualification to estimate how much it would cost at today's prices to study the feasibility of expanding its membership significantly. Of 74 that responded to the question, 51 percent estimated it would cost $50,000 or

less, 76 percent estimated $75,000 or less, and 96 percent estimated $100,000 or less. The average estimate was about $64,000.

Planning grants

Forty-seven respondents had received at least one planning grant during fiscal years 1975-78 to establish a new HMO; 15 had obtained two planning grants. The average amount of their first planning grants, including supplemental amounts, was about $141,000. However, as shown below, the average amount for each fiscal year had increased from about $122,000 in 1975 to about $175,000 in 1977. 1/ The 15 grantees that had received a second planning grant had obtained an average amount of $118,500, with amounts ranging from $40,000 to $200,000.

Amounts Of First Planning Grants Awarded To Establish New HMOs (note a)

Fiscal year	Number of respondents	Mean amount	Median amount	Range
1978	-	-	-	-
1977	7	$175,292	$199,600	$125,000-$200,000
1976	25	142,380	125,000	41,820-200,000
1975	15	122,461	124,995	103,492-125,000
Total	47	140,925	125,000	41,820-200,000

a/Includes supplemental grant amounts.

Of the 47 respondents, 45 said they had completed their planning activities, and 7 characterized the outcome of their planning stage as less than adequate. Only three said that lack of funds had caused their problems. They said they would have used additional funds for such things as additional project staff, facilities planning, consultants, and management information system planning.

1/In fiscal year 1978, OHMO awarded 13 planning grants; none of the respondents to our questionnaire received its first planning grant in 1978. The average amount of the 13 grants awarded in 1978 was $159,110.

We asked every respondent that had begun or completed its planning activities to estimate how much it would cost at today's prices to perform planning activities to establish a new HMO. Of 104 who responded to the question, 57 percent estimated it would cost $200,000 or less, 83 percent estimated $250,000 or less, and 95 percent estimated $400,000 or less. The average estimate was $216,000. The maximum amount available for planning is $400,000.

We asked each qualified HMO and each grantee that had applied for qualification to estimate how much it would cost at today's prices to plan for expanding membership significantly. Of the 72 who responded to the question, 51 percent estimated $100,000 or less and 81 percent estimated $200,000 or less. The average estimate was $135,000.

Initial development grants

Forty-eight respondents had received at least one initial development grant during fiscal years 1975-78 to initially develop a new HMO; only nine had received two initial development grants. The average amount of their first grants, including supplemental amounts, was about $622,000. However, as shown below, the average amount for each fiscal year had increased from about $438,000 in 1975 to about $813,000 in 1976 and then declined to about $541,000 in 1978. The nine grantees who obtained second grants received an average of $232,000, with amounts ranging from about $72,000 to $539,000.

Amounts Of First Initial Development Grants Awarded To Establish New HMOs (note a)

Fiscal year	Number of respondents	Mean amount	Median amount	Range
1978	9	$541,140	$397,467	$150,000-$1,000,000
1977	18	710,179	775,912	83,200-1,000,000
1976	8	812,626	983,390	482,888-1,000,000
1975	13	437,826	345,005	124,456-1,000,000
Total	48	621,796	571,254	83,200-1,000,000

a/Includes supplemental grant amounts.

Of the 48 respondents, 43 said they were either already qualified or expected to become qualified within 3 months. Only 4 of the 43 characterized the outcome of their initial development phase as less than adequate. Three of the four said lack of funds had hampered, at least to a moderate extent, their ability to meet their initial development goals. They said they would have used additional funds for such things as additional project staff, administrative and medical equipment, management information systems development, facilities renovation, and consultants.

We asked all respondents that had begun or completed initial development to estimate how much it would cost at today's prices to do the initial development activities necessary to establish a new HMO. Of 90 who responded to the question, 62 percent estimated $1 million or less and 97 percent estimated $2 million or less. The average estimate was $1.03 million. The maximum amount available will be $2 million beginning October 1, 1979; the current limit is $1 million.

We asked each qualified HMO and each grantee that had applied for qualification to estimate how much it would cost at today's prices to complete the initial development activities necessary to expand membership significantly. Of 70 who responded to the question, 56 percent estimated $500,000 or less, 73 percent estimated $1 million or less, and 96 percent estimated $2 million or less. The average estimate was about $836,000. In addition, it should be remembered that, as discussed in chapter 2, the HMO Amendments of 1978 authorized a program to lend an HMO up to $2.5 million to acquire or construct and equip an ambulatory health care facility. Such facilities are often a major part of an expansion effort; therefore, the new loan program can provide a major source of financing for expansion efforts.

FISCAL YEAR 1979 BUDGET UNCERTAINTIES MAY AFFECT DEVELOPMENT PROGRAM IN LATER FISCAL YEARS

As of March 1, 1979, the HMO grant program budget for fiscal year 1979 was still uncertain. No funds were appropriated for feasibility or planning grants for 1979 because the authorizations for them had expired in 1978 and had not been extended in time for appropriation action. Authorization for initial development grants had not expired.

Funding for feasibility and planning grants was provided under a continuing resolution, a mechanism that allows unauthorized programs to operate at the level of either the administration's proposed budget or the prior year's budget, whichever is lower. Consequently, as shown below, the grant program entered fiscal year 1979 under an interim budget of about $14.5 million, or about $9.4 million less than the administration's proposed budget.

In the amendments to the HMO Act passed in November 1978, the Congress authorized $31 million for fiscal year 1979 to fund the HMO grant program and two newly established HMO programs, a management intern training program and a technical assistance program. In response, OHMO has proposed a supplemental budget request that would increase the grant program budget to $29 million, as shown below.

The director of the Division of Development anticipates that the supplemental request will be approved. However, if OHMO were restricted to the interim fiscal year 1979 budget, the number of grants awarded would be greatly restricted. The supplemental budget would provide funding for 147 grants, but the interim budget would provide funding for only 84. OHMO officials pointed out that funding so few projects in 1979 would reduce the number of projects moving toward qualification during later fiscal years. If the supplemental request is approved, OHMO estimates the additional funds will result in about 38 new HMOs by fiscal year 1981.

Fiscal Year 1979 HMO Grant Program Budget

Type grant	Administration's proposed budget	Interim budget	Budget with supplemental request
		(millions)	
Feasibility	$ 5.25	$ 5.25	$ 6.0
Planning	10.60	1.20	10.0
Initial development	8.06	8.06	13.0
Total	$23.91	a/$14.51	$29.0

a/In addition, $1.547 million is available from unobligated fiscal year 1978 funds that were required to be set aside for rural HMO purposes.

CONCLUSIONS

We believe that grants awarded to developing HMOs should be sufficient to assure that the outcome of each grant phase is adequate. Responses to our questionnaire indicate that few respondents viewed the outcome of their grant phases as inadequate, and not all that characterized a particular grant phase as inadequate said lack of funds had caused the inadequacies.

In general, the amounts awarded to grantees have been well within the maximums prescribed by the act, as amended. Also, the amounts that the respondents estimated they would need to perform each grant phase at today's prices were generally within the maximums set by the act. Therefore, we do not believe the maximums need to be increased at this time.

Although the act provides for adequate assistance, uncertainties exist in the fiscal year 1979 grant program budget. OHMO has requested a supplemental appropriation that would allow funding of 147 grants, as opposed to 84 grants under its present budget. If only 84 grants were funded in 1979, the number of projects nearing qualification in later fiscal years would be reduced far below the potential numbers foreseen by OHMO.

This situation presents a strong argument for increasing the fiscal year 1979 appropriation. However, as pointed out in chapter 3, we believe staffing shortages may be imminent in OHMO's Loan Branch and Compliance Division. Large future increases in the number of qualified HMOs would serve to aggravate these problems unless additional staff can be assigned to these functions.

CHAPTER 5

PROBLEMS EXIST WITH POLICIES, PROCEDURES, AND STAFFING IN THE HMO GRANT PROGRAM, BUT OHMO IS TAKING CORRECTIVE ACTION

A primary purpose of the HMO grant program is to fund organizations through developmental stages until they meet Federal qualification standards. To do this effectively, both grantees and HEW personnel need a common understanding of specific requirements that must be met before a grantee can be designated as qualified. Without clearly defined requirements and criteria, HEW personnel cannot establish an effective strategy to guide grantees consistently through the development process, and grantees cannot plan their activities based on specific, clearly defined goals. In other words, all the players need to know the "rules of the game."

As of March 8, 1979, OHMO had neither published qualification guidelines which help define requirements for HMOs as set forth in Federal regulations nor issued adequate guidance to regional personnel on the outputs expected during each grant phase or the standards to be applied in reviewing grant applications. Although OHMO has initiated plans to publish qualification guidelines and issue new grant program guidance, we believe the absence of adequate guidance has hindered HEW's ability to administer the grant program clearly and consistently. In addition, two regional offices we reviewed are not adequately staffed for fiscal year 1979.

REGIONAL PERSONNEL NEED BETTER GUIDANCE TO DEVELOP NEW HMOs EFFECTIVELY

HEW regional offices and OHMO jointly administer the HMO grant program. Regional offices are the initial contact point for prospective grantees. Regional personnel help prospective grantees complete grant applications, review the applications for completeness and merit, recommend to OHMO whether applications should be approved, and monitor grantees' progress. However, because OHMO has final authority to approve grants and make qualification determinations, regional personnel must look to OHMO for guidance on the standards that OHMO applies when approving grants or qualifying HMOs.

The guidance OHMO provided was inadequate. As a result, regional personnel sometimes had given guidance to grantees that later was found to conflict with OHMO's views. According

to regional personnel, they lose credibility with grantees when this occurs. OHMO recognizes that the guidance provided to regional personnel needs improvement and has initiated a series of projects to correct the situation. However, OHMO's efforts were not far enough along for us to determine their effectiveness.

Examples of conflicting guidance

The following examples illustrate conflicting regional and OHMO interpretations and guidance provided to grantees proceeding through the grant phases toward qualification.

Example 1

A grantee had submitted an initial development grant application projecting a hospital utilization rate of 950 days per 1,000 persons based on local experience. The regional office viewed the application as excellent, but OHMO took exception to the hospital utilization rate and decided to provide the grantee a supplemental planning grant to revise the financial projections based on a lower utilization rate. The regional office found the grantee's revised rate of 800 days per 1,000 persons to be acceptable. After this revision, OHMO agreed to fund the project but required, as a grant condition, that the hospital utilization rate be further revised. OHMO wanted the grantee to submit another financial plan based on hospital utilization rates experienced by other HMOs of the same type.

Example 2

An individual practice association model HMO spent about 2-1/2 years becoming qualified. After the second of three site visits by regional and OHMO personnel, the region concluded that the HMO had met the qualification requirements. However, OHMO personnel rejected the grantee's plan for imposing risk on physicians who provide health services to HMO members. The risk plan was designed to give physicians an incentive to avoid unnecessary health service utilization. The HMO planned to impose a 10-percent risk; that is, the HMO would pay each physician only 90 percent of his billings. The remainder would go into a fund used to pay hospitalization costs should the costs be higher than expected. If costs were not higher than expected, the HMO would return the funds to the physicians. The OHMO site visit team found the 10-percent risk contracts unacceptable; however, the regional personnel had told the HMO that the risk plan was acceptable because it was the same as the plans of two other

qualified individual practice association HMOs in the region. HMO regulations make no reference to percentage of risk required.

Efforts are underway to provide better guidance to regions

Comments from regional personnel indicated that they viewed OHMO guidance as less than adequate. They made such comments as:

--OHMO sometimes makes grant and qualification decisions based on policies the regions are unaware of.

--Regions need more review criteria and updated grant guidelines in order to evaluate applicants consistently.

--OHMO needs to provide more guidance demonstrating the current state of the art for grant application preparation.

--Regional and OHMO qualification personnel have differing concepts about the necessary products for qualification. OHMO needs to standardize outputs expected during the developmental grant phases to prevent qualification delays resulting from different interpretations.

--OHMO needs to provide more written guidance; policy and procedures are too often disseminated orally.

--OHMO needs to provide more training on regulations, new amendments, and problem solving.

It was not only the regional personnel who noted the effects of inadequate grant and qualification guidance. The director of OHMO's Division of Qualification said that some grantees had taken longer than necessary to become qualified because of problems that could have been prevented had the grantees been guided properly through the developmental grant process. This problem was partly caused by a the lack of coordination between the qualification and development divisions before they were both placed within OHMO under the Assistant Secretary for Health in December 1977. In January 1979, the director of the Division of Qualification said OHMO had established a task force that was operating across divisional lines to identify coordination problems which could delay the qualification of grantees. However, in April 1979,

the director of OHMO said it would be at least December 1979 before OHMO could publish qualification guidelines that define requirements, or "rules of the game," for qualified HMOs.

In October 1978, OHMO's Division of Development set in motion plans to (1) update grant guidelines and standards for reviewing feasibility and planning grant applications, (2) prepare initial development grant review standards, which never existed before, and (3) define a grantee monitoring system. The division also instituted a system for informing regions about grant policy decisions. The division director believes these steps will result in more consistency among the regions and OHMO in administering the grant program. As of March 8, 1979, OHMO planned to issue the grant guidelines and review standards during May and June of 1979.

INADEQUATE STAFFING IS A PROBLEM IN TWO REGIONAL OFFICES

In our September 1976 report (see note, p. 1), we pointed out that HEW regional offices did not have the number or type of personnel needed to implement the HMO grant program. We also reported that downgrading of regional HMO program personnel had caused problems in recruiting competent professionals. Although this situation has improved, two regions still have staff shortages, and downgradings of regional HMO program positions have caused a morale problem and may hinder some regions' ability to recruit qualified personnel.

Two regions have staffing shortages

In an August 1978 memorandum, OHMO directed each region to prepare a fiscal year 1979 workplan. The memorandum described the regional program role as including the following basic activities.

--Reviewing applications for feasibility, planning, and initial development grants.

--Monitoring grantees.

--Monitoring adherence of qualified HMOs to loan agreements.

--Assisting in the qualification process.

--Assisting in compliance policy development.

--Assisting in monitoring qualified HMOs' compliance with the act.

--Assisting in monitoring employers' compliance with the act.

--Developing a regional plan to promote the HMO concept.

--Participating in intergovernmental relations.

--Providing technical assistance to non-federally-assisted HMOs.

Based on guidance provided by OHMO, each region prepared a fiscal year 1979 workplan. As shown below, 6 of the 10 regions projected a staffing shortage; only one was overstaffed.

Regional HMO Program Staffing For Fiscal Year 1979

Region	Actual number of positions allocated	Number needed per workplan	Staff surplus or shortage
I	6	7	-1
II	8	9	-1
III	6	6	0
IV	6	9	-3
V	7	8	-1
VI	7	6	+1
VII	4	4	0
VIII	6	6	0
IX	8	10	-2
X	6	7	-1
Total	64	72	-8

After receiving the workplans, OHMO negotiated adjustments to the workplans with the regions because of the projected staff shortages. OHMO officials said the workplan adjustments were made by reordering priorities. Also, adjustments were made where OHMO thought that regions had overstated their workloads in such areas as the number of new grants or the number of onsite visits to grantees by regional personnel. Four regional responsibilities were deemphasized by allowing regions to devote time to them only when time is available. They were (1) policy development, (2) employer compliance, (3) program promotion, and (4) intergovernmental relations. After the adjustments were made, only two regions lacked enough staff to meet their fiscal year 1979 workloads. We did not evaluate the reasonableness of the adjustments to the workplans.

Downgradings present morale and recruiting problems

Another problem in some regional offices was position downgradings. In one region, HEW had downgraded the regional HMO program consultant and an HMO public health advisor and denied promotions to the other HMO public health advisors. Regional personnel had appealed the decision based on their job duties, workload, and the fact that program consultants in other regions had been sustained at the GS-14 level and public health advisors at the GS-13 level. Regional personnel attributed the downgrading to their lack of authority to approve grants and their lack of supervisory responsibility because of the small size of the regional HMO staff. Although HEW has since reversed the decision to downgrade these regional personnel, other regions were experiencing similar problems. In one region, the regional program consultant expected to be unable to sustain his grade level for lack of authority to approve grants.

An additional problem caused by the grade structure is the inability to hire and retain competent staff with HMO experience. According to regional personnel, they cannot hire experienced personnel because of the higher salaries offered outside the Government. In one region, the regional program consultant expressed a need for additional experienced staff because the current staff was new and had limited HMO experience. Regional program consultants in each region we visited said they would have problems keeping experienced staff with a downgraded structure.

CONCLUSIONS

The HMO grant program has lacked adequate guidance on grant program policies and procedures and guidelines defining what a qualified HMO is. However, OHMO plans to publish qualification guidelines by December 1979, and has begun developing a series of various types of guidance that have the potential to establish more uniformity and clarity in the administration of the grant program. OHMO's efforts were not complete enough for us to judge their eventual effectiveness.

Staffing problems have eased since 1976. Although preliminary workplans for fiscal year 1979 indicated that six regions would have staff shortages, OHMO and the regions adjusted the workplans so that only two regions face staff shortages. The adjustments were made by reordering certain priorities and refining regional workload estimates that OHMO viewed as overstated.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW require that OHMO proceed as quickly as possible with its plans to publish qualification guidelines for developing HMOs and to develop improved grant program guidance for use by regional offices in order to establish more clarity and uniformity in the program.

AGENCY COMMENTS

HEW concurred in our recommendation and agreed that it is important to publish qualification guidelines and to improve grant program guidance. HEW pointed out several steps taken in the past year to carry out this recommendation:

--HEW has developed review standards for feasibility, planning, and initial development grants and for a monitoring visit during an HMO's initial development stage before it applies for qualification. Completion of these standards is targeted for early June 1979.

--HEW has developed policy issuances and program management bulletins to advise regional offices and grantees of new or existing policies.

--HEW has initiated a training program for regional personnel and grantees on management information systems.

--HEW has developed contract proposals to update a feasibility planning manual.

QUALIFIED HMOs RECEIVING FEDERAL FINANCIAL ASSISTANCE

UNDER THE HMO ACT OF 1973, AS AMENDED

JULY 1, 1975, THROUGH DECEMBER 31, 1978

Region	Organization	Grants					Total assistance
		Feasibility	Planning	Initial development	Total	Direct loan	
I	Community Health Care Center Plan, Inc. New Haven, Conn.	$ -	$ -	$ 362,461	$ 362,461	$ 2,090,000	$ 2,452,461
I	Connecticut Health Plan, Bridgeport, Conn.	75,000	103,492	967,550	1,146,042	2,500,000	3,646,042
I	Fallon Community Health Plan, Worcester, Mass.	49,585	-	760,613	810,198	1,527,000	2,337,198
I	Valley Health Plan, Amherst, Mass.	-	125,000	523,330	648,330	-	648,330
I	Matthew Thornton Health Plan, Inc. Nashua, New Hampshire	50,000	125,000	745,246	920,246	859,000	1,779,246
I	Rhode Island Group Health Assn., Providence, R.I.	50,000	-	1,492,255	1,542,255	2,500,000	4,042,255
II	Central Essex Health Plan, Orange, N.J.	-	93,145	951,462	1,044,607	2,178,000	3,222,607
II	CoMed, Inc., Cedar Knolls, N.J.	50,000	165,272	390,040	605,272	2,386,000	2,991,272
II	Crossroads Health Plan, East Orange, N.J.	85,000	132,121	493,800	[illegible]	2,500,000	3,200,921
II	Group Health Plan of New Jersey Guttenberg, N.J.	119,978	125,000	1,000,000	1,244,978	2,478,000	3,722,978
II	Health Care Plan of New Jersey, Cherry Hill, N.J.	66,590	299,995	721,174	1,087,759	1,771,000	2,858,759
II	Rutgers Community Health Plan, New Brunswick, N.J.	-	125,000	1,000,000	1,125,000	2,000,000	3,125,000
II	Southshore Health Plan, Inc., Northfield, N.J.	-	-	372,852	372,852	-	372,852
II	Capital Area Community Health Plan, Latham, N.Y.	-	315,464	1,545,932	1,861,396	2,500,000	4,361,396
II	Community Health Plan of Suffolk, Inc. Hauppauge, N.Y.	50,000	125,000	1,000,000	1,175,000	2,225,000	3,400,000
II	Genesee Valley Group Health Assn. Rochester, N.Y.	-	-	298,500	298,500	2,500,000	2,798,500
II	The Health Care Plan, Inc., Buffalo, N.Y.	-	273,807	1,000,000	1,273,807	2,500,000	3,773,807
II	Manhattan Health Plan, Inc., New York, N.Y.	49,876	125,000	999,611	1,174,487	2,500,000	3,674,487
II	Westchester Community Health Plan White Plains, N.Y.	-	114,902	1,000,000	1,114,902	2,500,000	3,614,902
III	Georgetown University Community Health Plan, Inc., Washington, D.C.	-	-	884,221	884,221	1,982,000	2,866,221
III	Group Health Assn., Inc., Washington, D.C.	50,000	-	-	50,000	-	50,000
III	HealthPlus, Inc., Riverdale, Md.	-	124,993	715,444	840,437	1,859,000	2,699,437
III	Metropolitan Baltimore Health Care, Inc. Baltimore, Md.	-	125,000	931,875	1,056,875	2,500,000	3,556,875
III	Greater Delaware Valley Health Care, Inc. Radnor, Pa.	-	41,820	836,379	878,199	1,793,000	2,671,199
III	HMO of Pennsylvania, Willow Grove, Pa.	42,906	108,235	663,965	815,106	2,500,000	3,315,106
III	Health Service Plan of Pennsylvania Philadelphia, Pa.	-	-	227,610	227,610	2,213,000	2,440,610
III	Penn Group Health Plan Pittsburgh, Pa.	-	-	1,498,777	1,498,777	2,300,000	3,798,777
IV	American Health Plan, North Miami Beach, Fla.	-	-	-	-	1,182,000	1,182,000
IV	Av-Med Health Plan, Inc., Miami, Fla.	-	-	-	-	1,100,000	1,100,000
IV	Florida Health Care Plan, Inc., Daytona Beach, Fla.	-	-	124,456	124,456	2,500,000	2,624,456
IV	Prepaid Health Care, Inc., Clearwater, Fla.	80,128	123,756	1,000,000	1,203,884	2,500,000	3,703,884
IV	HealthCare of Louisville, Inc., Louisville, Ky.	-	120,566	1,006,806	1,127,372	2,500,000	3,627,372

APPENDIX I

APPENDIX I

Region	Organization	Grants				Loans		Total assistance
		Feasibility	Planning	Initial development	Total	Direct loan		
1/	Piedmont Health Care Corp., Greenville, S.C.	$ 70,860	$ -	$ -	$ 70,860	$ -	$	70,860
5	Anchor Organization for Health Maintenance Orleans, Ill.	74,005	-	704,723	778,728	-		778,728
	South Cook Counties Health Plan, Evanston, Ill.	75,000	-	788,628	863,628	2,500,000		3,363,628
5	Group Health Plan of Southeast Michigan (Warren, Mich.	-	427,429	996,334	1,423,763	2,900,000		4,323,763
	[illegible] Inc., Langsing, Mich.	70,000	271,064	1,900,000	2,241,064	2,500,000		4,741,064
	Western Reserve Plan, Indianapolis, Ind.	-	-	-	-	2,295,000		2,295,000
5	Yale-New Haven Health [illegible]	-	-	466,144	466,144	-		466,144
5	[illegible] Plan, Inc., Utica, Mich.	1,[illegible]	-	450,000	570,000	950,000		1,520,000
5	[illegible] Health Foundation, Berkeley, Calif.	94,915	-	944,119	1,039,034	-		1,039,034
	[illegible] Health Plan, Inc., [illegible]	70,000	[illegible]	1,850,000	[illegible]	2,500,000		[illegible]
	[illegible] Health Plan of [illegible]	-	[illegible]	[illegible]	[illegible]	2,500,000		2,500,000
1	[illegible] Health Plan, Inc., Wallingford, Conn.	-	[illegible]	1,000,000	[illegible]	2,500,000		3,500,000
1	[illegible] Health Plan, Inc., Bangor, Maine	47[illegible]	[illegible]	990,[illegible]	[illegible]	2,500,000		[illegible]
1	[illegible] Health Plan, Inc., Fall River, Mass.	-	[illegible]	693,528	[illegible]	2,[illegible]		[illegible]
1	[illegible] Health Plan (Cooperative) [illegible]	49,[illegible]	[illegible]	990,000	[illegible]	2,[illegible]		[illegible]
1	[illegible] Health Plan (Blue Health) [illegible]	-	[illegible]	2,000,000	[illegible]	2,[illegible]		[illegible]
1	[illegible] Health Plan, Inc.	-	-	-	-	-		-
1	[illegible] Health Plan, Inc., Boston, Mass.	[illegible]	[illegible]	58,497	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	-	-	-	-		-
1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	[illegible]	625,920	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	-	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
5	[illegible]	-	[illegible]	963,675	[illegible]	[illegible]		[illegible]
5	[illegible] Health Plan, Inc., Rochester, N.Y.	-	[illegible]	[illegible],000	[illegible]	[illegible]		[illegible]
5	[illegible] Health Plan, Inc., Akron, Ohio	49,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
5	[illegible] Health Plan, Inc., Portland, Oreg.	-	[illegible]	435,183	[illegible]	[illegible]		[illegible]
5	Kaiser Foundation Health Plan of Northwest Spokane, Wash.	50,000	[illegible]	995,980	[illegible]	[illegible]		[illegible]
5	Group Health Association, Washington, D.C.	-	-	804,738	[illegible]	[illegible]		[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]

a/Eight Comprehensive Health Plans for $4,[illegible] are included in this total.

b/Five [illegible] Health Plans for $804,192 are included in this total.

c/Six Initial Development Organization Grants for $2,947,[illegible] are included in this total.

d/Thirteen Comprehensive Health Plans for $2,[illegible] are included in this total.

HMO ACT GRANTS AWARDED DURING FISCAL YEARS 1975-79 (note a)

Fiscal year	Feasibility grants		Planning grants		Initial development grants		Total	
	Number	Amount	Number	Amount	Number	Amount	Number	
1979 (note b)	8	$ 523,139	5	$ 798,185	10	$ 4,586,251	23	$ 5
1978	66	4,543,193	13	2,068,433	21	10,367,195	100	16
1977	5	208,686	15	2,223,133	26	14,515,510	46	16
1976 (note c)	11	509,370	41	5,080,602	20	12,580,368	72	18
1975	108	5,196,281	31	3,758,745	33	13,507,274	172	22
Total	198	$10,980,669	105	$13,929,098	110	$55,556,598	413	$80

a/Supplemental grants are not counted as separate grants in the "number" column. Supplemental grant amounts are included in the "amount" column.

b/Fiscal year 1979 data are as of 2/28/79.

c/Fifteen-month fiscal year.

APPENDIX III

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

January 5, 1979

In October 1978, the U.S. Congress enacted the Health Maintenance Organization Amendments of 1978. The amendments require the U.S. General Accounting Office (GAO) to assess the adequacy of amounts of financial assistance (grants and loans) available under the HMO Act, as amended. Part of our effort to make this assessment involves obtaining information from HMO grantees and qualified HMOs.

The enclosed questionnaire has been developed to obtain your ideas on the adequacy of financial assistance available under the HMO Act, as amended. Your organization was chosen from a list of grantees and qualified HMOs provided to us by the Office of Health Maintenance Organizations, Department of Health, Education, and Welfare. Your organization's response is of great importance to our review.

The information which you provide will be treated in strict confidence. Your individual responses will not be made available to HEW or to any persons other than the GAO staff members working directly on this review. Your candid responses will assist us greatly in reporting to the Congress information which could be vital to the success of the HMO program.

Any report based on this review will summarize the responses and will not identify specific grantees or qualified HMOs. A copy of this report will be sent to those organizations which provide information to us.

Please complete and return the questionnaire in the enclosed postage paid envelope within the next 5 days. If you have any questions, please call Ira Spears or Paul Pansini on (404) 221-4616.

Thank you for your cooperation.

Sincerely yours,

Robert V. Parabaugh
Assistant Director
Human Resources
Division

Enclosures

APPENDIX III

U.S. GENERAL ACCOUNTING OFFICE
SURVEY OF ORGANIZATIONS CONCERNING GRANTS
AND LOANS AVAILABLE UNDER THE HMO ACT

(1-3)

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The HMO Act, as amended, authorizes HEW to award grants to a public or private nonprofit organization to help cover the costs of feasibility studies, planning, and initial development activities in order to:

(1) establish a new qualified HMO,
(2) expand significantly the membership or service area of an operational qualified HMO, or
(3) convert the status of an operational nonqualified HMO to a qualified status.

Feasibility study activities include identifying target population groups and potential providers, estimating subscriber and facility requirements, and identifying State laws, regulations, and practices relating to HMOs.

Planning activities include recruiting key staff; establishing community support; developing a formal organization, health benefits plan, premium structure, marketing plan, and financial plan; identifying basic health services providers; and planning for necessary facilities and equipment.

Initial development activities include recruiting and training essential personnel, developing a comprehensive financial plan, organizing physicians and other basic health services, constructing/renovating facilities, organizing ambulatory care facilities, and initiating an enrollment plan.

The HMO Act, as amended, also authorizes HEW to make loans to a qualified HMO to:

(1) cover operating losses incurred during the first 5 years of operation as a qualified HMO and
(2) acquire/construct and equip ambulatory health care facilities.

This questionnaire seeks your experiences with and opinions about these grant and loan programs.

1. We realize that several people may be involved in filling out this questionnaire. However, we would like the name, title, address and telephone number of the one person we should contact if further information is required.

_____
(NAME)

_____
(TITLE)

_____
(ORGANIZATION)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP CODE)

_____
(AREA CODE) (TELEPHONE)

APPENDIX III

2. In what year did your organization, or its predecessors, first decide to look into the possibility of providing medical services on a prepaid basis? (Check one) (5)

   1. ☐ Before 1960
   2. ☐ Between 1960 and 1970
   3. ☐ Between 1971 and 1973
   4. ☐ Between 1974 and 1978

3. In what phase is your HMO (Check one) (6)

   1. ☐ Feasibility survey phase
   2. ☐ Planning phase (GO TO QUESTION 8)
   3. ☐ Initial development phase but not operational
   4. ☐ Initial development phase - operational but not Federally qualified (GO TO QUESTION 4)
   5. ☐ Federally qualified HMO

4. Is your HMO presently providing medical services on a prepaid basis? (Check one) (7)

   1. ☐ Yes (GO TO QUESTION 5)
   2. ☐ No (GO TO QUESTION 8)

5. As of December 31, 1978, how many members was your HMO serving on a prepaid basis? (Enter the approximate number) (8-13)

   _____ individuals

6. In what year did your HMO first provide medical services on a prepaid basis? (Check one) (14)

   1. ☐ Before 1960
   2. ☐ Between 1960 and 1970
   3. ☐ Between 1971 and 1973
   4. ☐ Between 1974 and 1978

7. At how many locations does your HMO provide outpatient services to its members? (Insert the number.) (15)

   _____ locations

8. What HMO model is your HMO using or does it intend to use once it becomes operational? (Check one) (16)

   1. ☐ Staff model - the HMO employs a staff of physicians and other health professionals to provide health care services.
   2. ☐ Group practice model - the HMO contracts with a medical group to provide health care services.
   3. ☐ I.P.A. (Individual Practitioners' Association) - association of individual practitioners working out of their own offices who contract with the HMO to provide health care services to HMO members.
   4. ☐ Combination of staff and group practice models - the HMO employs some physicians and/or other health professionals and also contracts with a medical group to provide health care services.
   5. ☐ Combination of IPA and staff models.
   6. ☐ Combination of IPA and group practic models.

FEASIBILITY STUDY GRANTS

9. Assume that your HMO does not exist in its present form and that your organization has decided to do a survey to determine the feasibility of establishing a new HMO of the same type as yours and in the same area. How much do you estimate a feasibility study would cost at today's prices? (Insert the amount.) (17-22)

   $_____

10. Did your organization, or its predecessors, receive a Federal grant under the HMO Act to perform a feasibility study? (Check one) (23)

    1. ☐ Yes (GO TO QUESTION 11)
    2. ☐ No (GO TO QUESTION 26)

11. During what month and year did your organization apply for your feasibility grant? (first feasibility grant only if you have applied for more than one such grant.)

    _____ (Month) _____ (Year)

12. In what month and year did HEW award your feasibility grant? (first feasibility grant only if you have been awarded more than one such grant.)

    _____ (Month) _____ (Year)

    / / / (24-25)

APPENDIX III

13. What was the purpose of your feasibility grant? (first feasibility grant only) (Check one) (26)

1. ☐ To determine the feasibility of establishing a new qualified HMO. (GO TO QUESTION 14)
2. ☐ To determine the feasibility of significantly expanding the membership or service area of an already operational qualified HMO. (GO TO QUESTION 26)
3. ☐ To determine the feasibility of converting the status of an already operational nonqualified HMO to a qualified status. (GO TO QUESTION 26)

14. How adequate was the application kit that HEW provided to you to apply for the feasibility grant? (first feasibility grant only) (27) (Check one)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

15. How timely was HEW's processing of your feasibility grant application? (first feasibility grant only) (Check one) (28)

1. ☐ Very timely
2. ☐ Somewhat timely
3. ☐ Neither timely nor untimely
4. ☐ Somewhat untimely
5. ☐ Very untimely

16. How adequately was the assistance provided by HEW personnel during the feasibility grant application process? (first feasibility grant only)? (Check one.) (29)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

17. Has your organization completed its feasibility survey? (Check one) (30)

1. ☐ Yes (GO TO QUESTION 18)
2. ☐ No (GO TO QUESTION 26)

18. How adequate was the outcome of your feasibility study compared to the goals you had for the study? (Check one) (31)

1. ☐ Very adequate
2. ☐ Somewhat adequate

(GO TO QUESTION 21)

3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

(GO TO QUESTION 19)

19. To what extent did insufficient funds play a role in hampering your ability to meet your feasibility study goals? (Check one) (32)

1. ☐ Very great extent
2. ☐ Substantial extent
3. ☐ Moderate extent

(GO TO QUESTION 20)

4. ☐ Some extent
5. ☐ Little or no extent

(GO TO QUESTION 21)

20. What would your organization have used additional feasibility funds for, if available? (Check all that apply)

1. ☐ Additional project staff (33)
2. ☐ Additional consultants (34)
3. ☐ Training for project staff (35)
4. ☐ Other (specify) _____

_____ (36)

APPENDIX III

21. Did your organization need technical assistance (e.g. marketing, financial management, actuarial science, etc.) during the feasibility study? (Check one) (37)

1. ☐ Yes (GO TO QUESTION 22)
2. ☐ No (GO TO QUESTION 26)

22. Did you obtain technical assistance from HEW personnel? (Check one) (38)

1. ☐ Yes (GO TO QUESTION 23)
2. ☐ Did not seek assistance from HEW. (GO TO QUESTION 24)
3. ☐ Sought assistance from HEW, but did not get any. (GO TO QUESTION 24)

23. How adequate was the technical assistance you received from HEW personnel? (Check one) (39)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

24. Did you obtain technical assistance from consultants? (Check one) (40)

1. ☐ Yes (GO TO QUESTION 25)
2. ☐ Did not seek assistance from consultants. (GO TO QUESTION 26)
3. ☐ Sought assistance from consultants, but could not get any. (GO TO QUESTION 26)

25. How adequate was the technical assistance you received from consultants? (Check one) (41)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

PLANNING GRANTS

26. Has your organization begun or already completed the planning activities necessary to establish a new HMO (regardless of how those activities were funded or how long ago they were completed)? (Check one) (42)

1. ☐ Yes (GO TO QUESTION 27)
2. ☐ No (GO TO QUESTION 87)

27. Assume that your organization has reached the stage at which it is ready to do the planning needed to establish a new HMO of the same type as yours and in the same area. How much do you estimate the planning phase would cost at today's prices? (Insert amount)

$_____ (43-48)

28. Did your organization, or its predecessors, receive a Federal grant under the HMO Act to perform the planning needed to establish your HMO? (Check one) (49)

1. ☐ Yes (GO TO QUESTION 29)
2. ☐ No (GO TO QUESTION 44)

29. During what month and year did your organization apply for your planning grant? (first grant only, if you have applied for more than one.)

_____ (Month) _____ (Year)

30. In what month and year did HEW award your planning grant? (first grant only, if you have applied for more than one.)

_____ (Month) _____ (Year)

/ / / (50-51)

APPENDIX III

31. What was the purpose of your planning grant? (first planning grant only) (Check one) (52)

1. ☐ To plan for the establishment of a new qualified HMO. (GO TO QUESTION 32)
2. ☐ To plan for the significant expansion of the membership or service area of an already operational qualified HMO. (GO TO QUESTION 44)
3. ☐ To plan for converting the status of an already operational nonqualified HMO to a qualified status. (GO TO QUESTION 44)

32. How adequate was the application kit that HEW provided to you to apply for your planning grant? (first planning grant only) (Check one) (53)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very adequate

33. How timely was HEW's processing of your planning grant application? (first planning grant only) (Check one) (54)

1. ☐ Very timely
2. ☐ Somewhat timely
3. ☐ Neither timely nor untimely
4. ☐ Somewhat untimely
5. ☐ Very untimely

34. How adequate was the assistance provided by HEW personnel during the planning grant application process? (first planning grant only) (Check one) (55)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

35. Has your organization completed its planning phase? (Check one) (56)

1. ☐ Yes (GO TO QUESTION 36)
2. ☐ No (GO TO QUESTION 44)

36. How adequate was the outcome of this phase compared to the goals you had for this phase? (Check one) (57)

1. ☐ Very adequate
2. ☐ Somewhat adequate

(GO TO QUESTION 39)

3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

(GO TO QUESTION 37)

37. To what extent did insufficient funds play a role in hampering your ability to meet your planning goals? (Check one) (58)

1. ☐ Very great extent
2. ☐ Substantial extent
3. ☐ Moderate extent

(GO TO QUESTION 38)

4. ☐ Some extent
5. ☐ Little or no extent

(GO TO QUESTION 39)

38. What would your organization have used additional planning funds for, if available? (Check all that apply)

1. ☐ Additional project staff (59)
2. ☐ Additional facilities planning (e.g. architectural fees) (60)
3. ☐ Additional consultants (61)
4. ☐ Additional management information systems planning (62)
5. ☐ Other (Please specify) _____ (63)

39. Did your organization need technical assistance (e.g. marketing, financial management, actuarial science, etc.) during the planning stage? (Check one) (64)

1. ☐ Yes (GO TO QUESTION 40)
2. ☐ No (GO TO QUESTION 44)

APPENDIX III

40. Did you obtain technical assistance from HEW personnel? (Check one) (65)

1. ☐ Yes (GO TO QUESTION 41)
2. ☐ Did not seek assistance from HEW. (GO TO QUESTION 42)
3. ☐ Sought assistance from HEW, but did not get any. (GO TO QUESTION 42)

41. How adequate was the technical assistance you received from HEW personnel? (Check one) (66)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

42. Did you obtain technical assistance from consultants? (Check one) (67)

1. ☐ Yes (GO TO QUESTION 43)
2. ☐ Did not seek assistance from consultants. (GO TO QUESTION 44)
3. ☐ Sought assistance from consultants, but could not get any. (GO TO QUESTION 44)

43. How adequate was the technical assistance you received from consultants? (Check one) (68)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

INITIAL DEVELOPMENT GRANTS

44. Has your organization begun or already completed the initial development activities necessary to establish a new HMO (regardless of how those activities were funded or how long ago they were completed)? (Check one) (69)

1. ☐ Yes (GO TO QUESTION 45)
2. ☐ No (GO TO QUESTION 87)

45. Assume that your HMO has just reached the point at which it is ready to begin initial development as a new HMO, of the same type as yours and in the same area. How much do you estimate the initial development phase would cost at today's prices? (Insert amount.)

$_____ (70-76)

46. Did your organization, or its predecessors, receive an initial development grant under the HMO Act? (Check one) (77)

1. ☐ Yes (GO TO QUESTION 47)
2. ☐ No (GO TO QUESTION 62)

47. During what month and year did your organization apply for your initial development grant? (first initial development grant only if you have applied for more than one such grant.)

____ (Month) ____ (Year)

48. In what month and year did HEW award your initial development grant? (first initial development grant only if you have been awarded more than one such grant.)

____ (Month) ____ (Year)

/ / / (78-79)

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APPENDIX III

49. What was the purpose of your initial development grant? (first initial development grant only) (Check one) (5)

1. ☐ To accomplish initial development activities needed to establish a new qualified HMO. (GO TO QUESTION 50)
2. ☐ To accomplish initial development activities needed to significantly expand the membership or service area of an already operational qualified HMO.
3. ☐ To accomplish initial development activities needed to convert the status of an already operational nonqualified HMO to a qualified status. (GO TO QUESTION 62)

50. How adequate was the application kit that HEW provided to you to apply for the initial development grant? (first initial development grant only) (Check one) (6)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

51. How timely was HEW's processing of your initial development grant application? (first initial development grant only) (Check one) (7)

1. ☐ Very timely
2. ☐ Somewhat timely
3. ☐ Neither timely nor untimely
4. ☐ Somewhat untimely
5. ☐ Very untimely

52. How adequate was the assistance provided by HEW personnel during the initial development grant application process? (first initial development grant only) (Check one) (8)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

53. Is your organization a qualified HMO or do you anticipate it will become qualified within the next 3 months? (Check one) (9)

1. ☐ Yes (GO TO QUESTION 54)
2. ☐ No (GO TO QUESTION 62)

54. Consider those tasks that your organization set out to accomplish during its initial development phase. How adequate a job was done in accomplishing these tasks? (Check one) (10)

1. ☐ Very adequate
2. ☐ Somewhat adequate

(GO TO QUESTION 57)

3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

(GO TO QUESTION 55)

55. To what extent did insufficient funds play a role in hampering your ability to meet your initial development goals? (Check one) (11)

1. ☐ Very great extent
2. ☐ Substantial extent
3. ☐ Moderate extent

(GO TO QUESTION 56)

4. ☐ Some extent
5. ☐ Little or no extent

(GO TO QUESTION 67)

APPENDIX III

56. What would your organization have used additional initial development funds for, if available? (Check all that apply.)

1. ☐ Additional project staff (12)
2. ☐ Administrative equipment (13)
3. ☐ Medical equipment (14)
4. ☐ Management information system development (15)
5. ☐ Facilities renovation (16)
6. ☐ Additional consultants (17)
7. ☐ Other (Please specify) _____

_____ _____ (18)

57. Did your organization need technical assistance (e.g. marketing, financial management, actuarial science, etc.) during the initial development phase? (Check one) (19)

1. ☐ Yes (GO TO QUESTION 58)
2. ☐ No (GO TO QUESTION 62)

58. Did you obtain technical assistance from HEW personnel? (Check one) (20)

1. ☐ Yes (GO TO QUESTION 59)
2. ☐ Did not seek assistance from HEW. (GO TO QUESTION 60)
3. ☐ Sought assistance from HEW, but did not get any. (GO TO QUESTION 60)

59. How adequate was the technical assistance you received from HEW personnel? (Check one) (21)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

60. Did you obtain technical assistance from consultants? (Check one) (22)

1. ☐ Yes (GO TO QUESTION 61)
2. ☐ Did not seek assistance from consultants. (GO TO QUESTION 62)
3. ☐ Sought assistance from consultants, but did not get any. (GO TO QUESTION 62)

61. How adequate was the technical assistance you received from consultants? (Check one) (23)

1. ☐ Very adequate
2. ☐ Somewhat adequate
3. ☐ Neither adequate nor inadequate
4. ☐ Somewhat inadequate
5. ☐ Very inadequate

62. Has your HMO applied for Federal qualification? (Check one) (24)

1. ☐ Yes (GO TO QUESTION 63)
2. ☐ No (GO TO QUESTION 68)

63. On what date, did your HMO apply for qualification?

(Month) (Day) (Year)

/ / / / (25-27)

64. How timely was HEW's processing of your application for qualification? (Check one) (28)

1. ☐ Very timely
2. ☐ Somewhat timely

(GO TO QUESTION 68)

3. ☐ Neither timely nor untimely
4. ☐ Somewhat untimely
5. ☐ Very untimely

(GO TO QUESTION 65)

6. ☐ Not enough time has elapsed to make this judgement

(GO TO QUESTION 68)

APPENDIX III

65. Could your HMO have started operating as a qualified HMO earlier than it did (or will) if HEW had been more timely in processing your application for qualification? (Check one) (29)

1. /___/ Yes (GO TO QUESTION 66)
2. /___/ No (GO TO QUESTION 68)

66. In what month and year could your HMO have started operating as a qualified HMO if HEW had processed your qualification application in a more timely manner?

_____ _____
(Month) (Year)

/___/___/ (30-31)

67. How much of your initial development grant expenditures could have been avoided if HEW had qualified your HMO in a more timely manner? (Insert amount)

$_____ (32-38)

OPERATING DEFICIT LOANS

68. What amount in operating deficit loan assistance do you believe should be available to a newly developed HMO of the same type as your HMO and in the same area? (Insert amount)

$_____ (39-45)

69. After how many years of operation as a qualified HMO is it reasonable to expect an HMO such as yours and in the same area to operate without Federal financial assistance? (Insert number of years)

_____ Years (46-47)

70. What is the status of your HMO? (Check one) (48)

1. /___/ Federally qualified (GO TO QUESTION 71)
2. /___/ Have applied for Federal qualification (GO TO QUESTION 81)
3. /___/ Neither qualified nor have applied for qualification (GO TO QUESTION 87)

71. Has your HMO received or applied for a Federal loan to cover operating deficits? (Check one) (49)

1. /___/ Yes (GO TO QUESTION 72)
2. /___/ No (GO TO QUESTION 81)

72. Consider your HMO's most recent application for an operating deficit loan. On what date was this application made?

_____ _____ _____
(Month) (Day) (Year)

/___/___/ (50-52)

73. How adequate was the application kit which HEW provided to you for your most recent loan application? (Check one) (53)

1. /___/ Very adequate
2. /___/ Somewhat adequate
3. /___/ Neither adequate nor inadequate
4. /___/ Somewhat inadequate
5. /___/ Very inadequate

74. How timely was HEW's processing of your most recent application for a Federal operating deficit loan? (Check one) (54)

1. /___/ Very timely
2. /___/ Somewhat timely
3. /___/ Neither timely nor untimely
4. /___/ Somewhat untimely
5. /___/ Very untimely
6. /___/ Not enough time has elapsed to make this judgment

75. How adequate was the assistance provided by HEW personnel during this loan application process? (Check one) (55)

1. /___/ Very adequate
2. /___/ Somewhat adequate
3. /___/ Neither adequate nor inadequate
4. /___/ Somewhat iandequate
5. /___/ Very inadequate

76. Has your HMO needed technical assistance (e.g. marketing, financial management, actuarial science) after becoming qualified? (Check one) (56)

1. /___/ Yes (GO TO QUESTION 77)
2. /___/ No (GO TO QUESTION 81)

APPENDIX III

77. Did you obtain technical assistance from HEW personnel? (Check one) (57)

1. /___/ Yes (GO TO QUESTION 78)
2. /___/ Did not seek assistance from HEW. (GO TO QUESTION 79)
3. /___/ Sought assistance from HEW, but did not get any. (GO TO QUESTION 79)

78. How adequate was the technical assistance you received from HEW personnel? (Check one) (58)

1. /___/ Very adequate
2. /___/ Somewhat adequate
3. /___/ Neither adequate nor inadequate
4. /___/ Somewhat inadequate
5. /___/ Very inadequate

79. Did you obtain technical assistance from consultants? (Check one) (59)

1. /___/ Yes (GO TO QUESTION 80)
2. /___/ Did not seek assistance from consultants (GO TO QUESTION 81)
3. /___/ Sought assistance from consultants, but could not get any. (GO TO QUESTION 81)

80. How adequate was the technical assistance you received from consultants? (Check one) (60)

1. /___/ Very adequate
2. /___/ Somewhat adequate
3. /___/ Neither adequate nor inadequate
4. /___/ Somewhat inadequate
5. /___/ Very inadequate

AMBULATORY HEALTH CARE FACILITY LOANS

81. Does your HMO anticipate applying to HEW for a loan (or loans) to acquire/construct and equip ambulatory health care facilities within the next 2 years? (Check one) (61)

1. /___/ Yes (GO TO QUESTION 82)
2. /___/ No
3. /___/ Uncertain (GO TO QUESTION 84)

82. For how many ambulatory health care facilities do you anticipate applying to HEW for loan assistance in the next 2 years? (Enter number)

_____ facilities (62)

Begin Card 3

Code (1-3)

/ 3 /
4

83. For each ambulatory health care facility that you anticipate applying to HEW for loan assistance indicate (1) the approximate size in square feet and (2) the approximate amount of loan assistance you would need to purchase or construct and equip the facility.

Facility	Size	Loan Amount	
(1)	sq. ft.	$	(5-7) (8-14)
(2)	sq. ft.	$	(15-17) (18-24)
(3)	sq. ft.	$	(25-27) (28-34)
(4)	sq. ft.	$	(35-37) (38-44)
(5)	sq. ft.	$	(45-47) (48-54)

EXPANSION GRANTS

84. How much do you estimate it would cost your HMO at today's prices to perform an adequate survey to determine the feasibility of significantly expanding its membership or service area. (Enter amount)

$_____ (55-60)

85. How much do you estimate it would cost your HMO at today's prices to adequately plan for significantly expanding its membership or service area. (Enter amount)

$_____ (61-66)

86. How much do you estimate it would cost your HMO at today's prices to adequately complete the initial development necessary to significantly expand its membership or service area? (Enter amount)

$_____ (67-73)

APPENDIX III

87. If you have any comments you would like to make about specific questions, the questionnaire in general or other matters such as changes in the HMO Act that you believe are needed, please do so on this sheet. (74)

APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

NOTES

1. Cost, revenue, and membership data are based on data from unaudited quarterly reports submitted by HMOs to HEW under the HMO National Data Reporting Requirements (OMB No. 68R-1496).

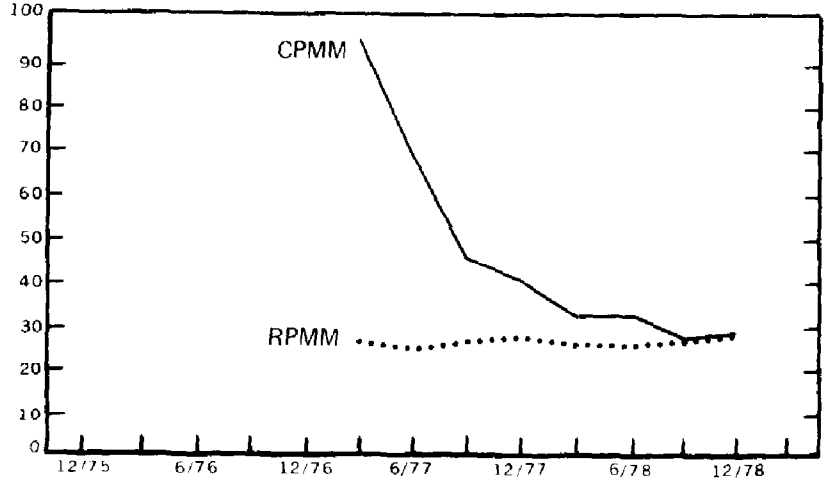
2. CPMM = cost per member month.

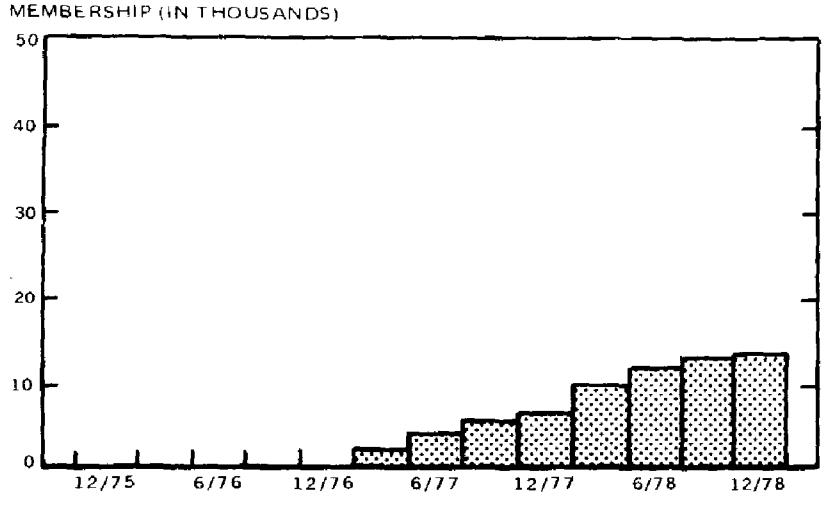
3. RPMM = revenue per member month.

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

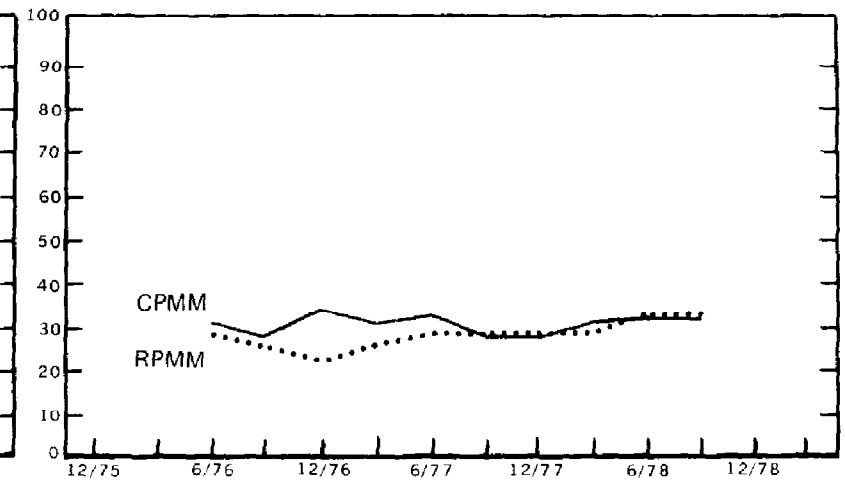
(SEE NOTES ON PAGE 69)

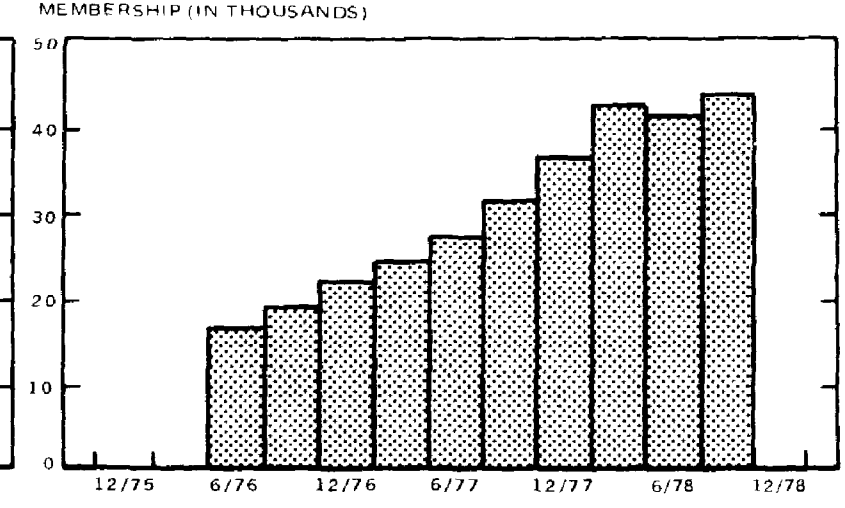
HMO 1





HMO 2



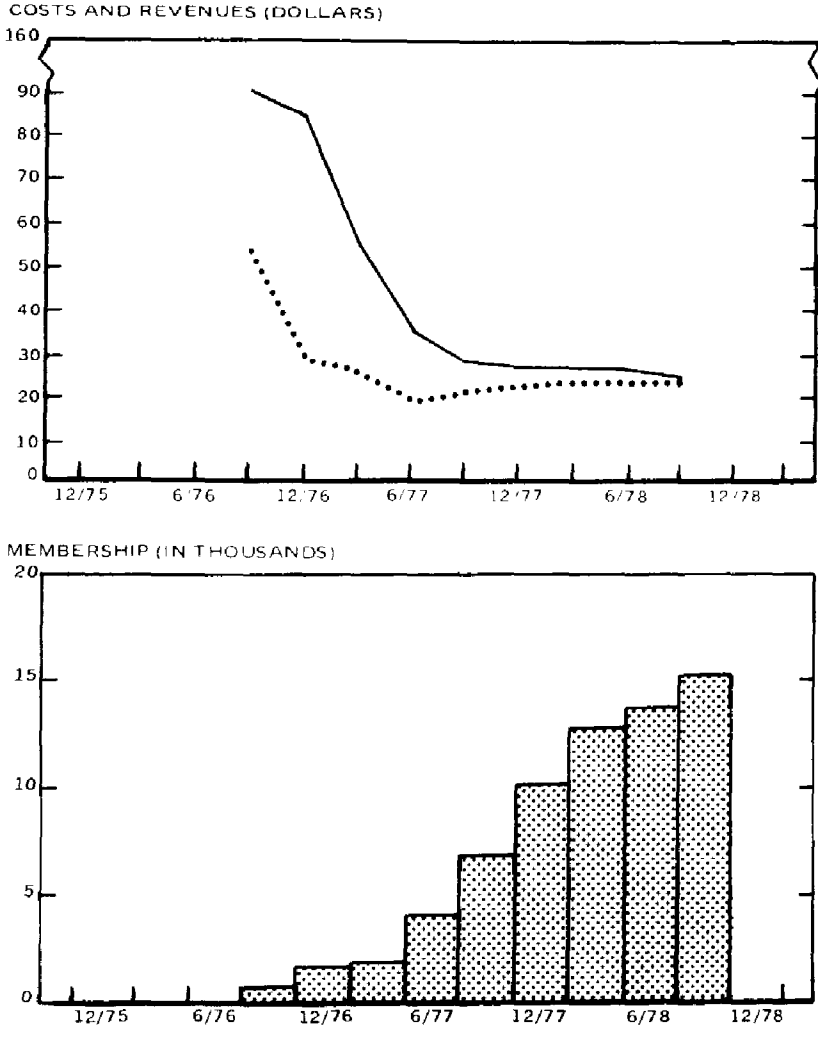


APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 69)

HMO NO. 3



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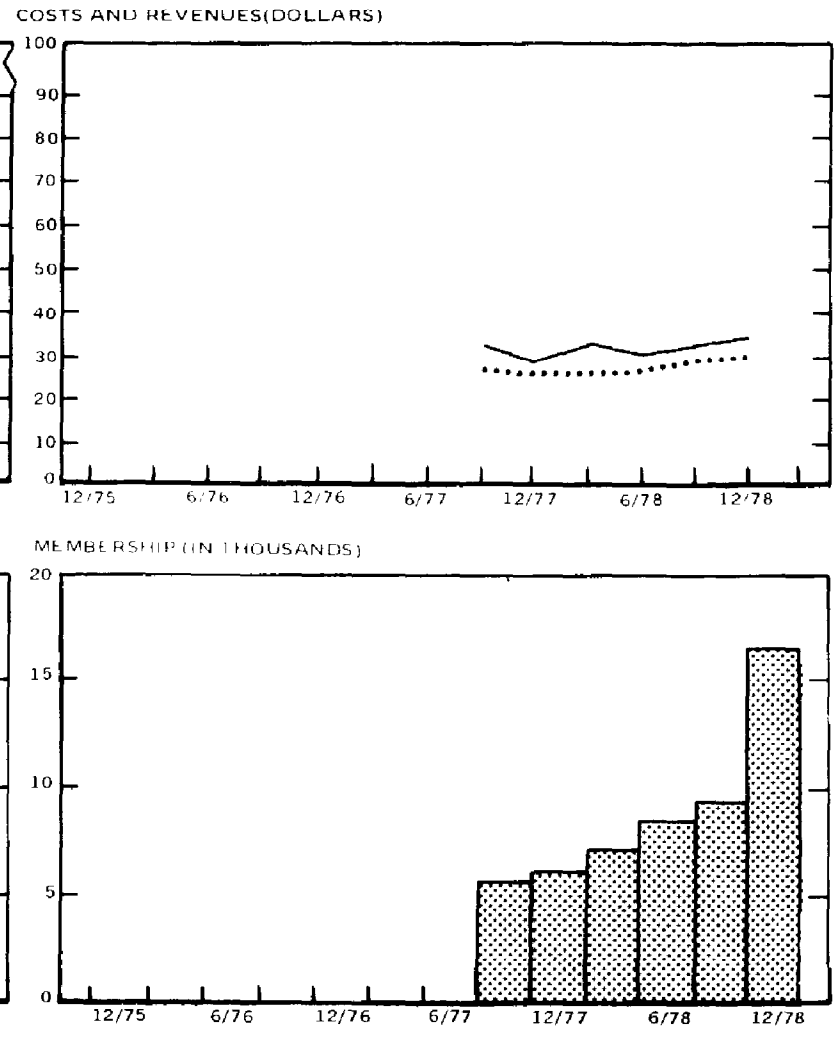
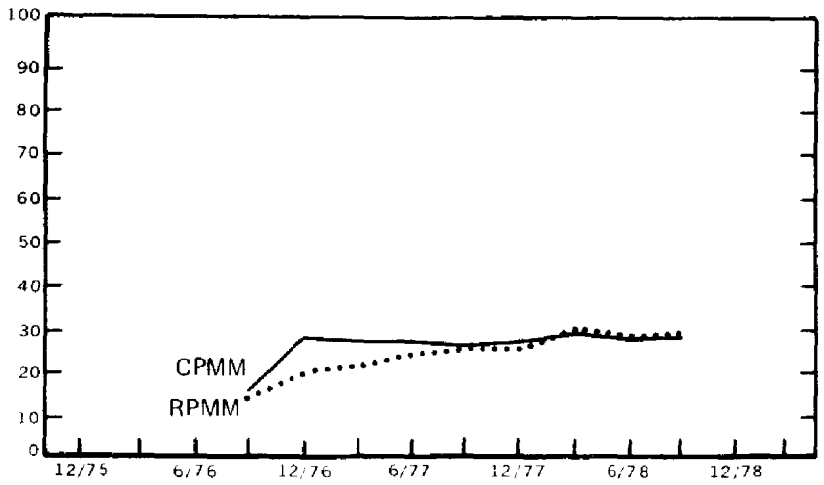


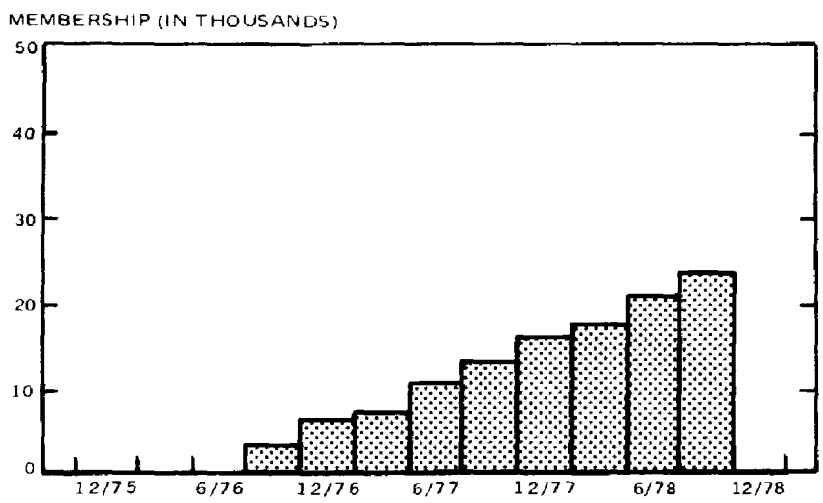
APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

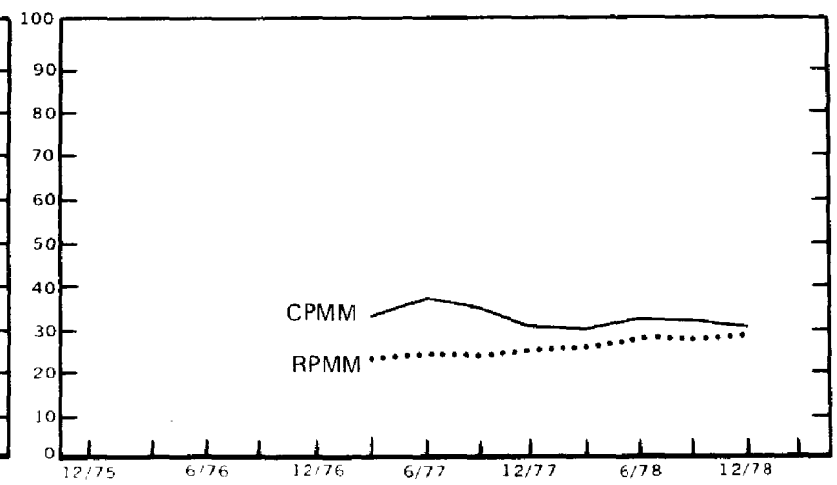
(SEE NOTES ON PAGE 69)

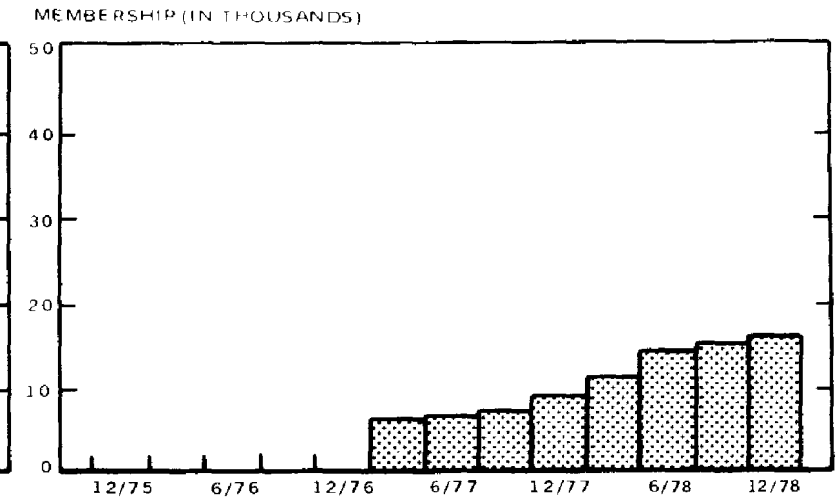
HMO 5





HMO 6



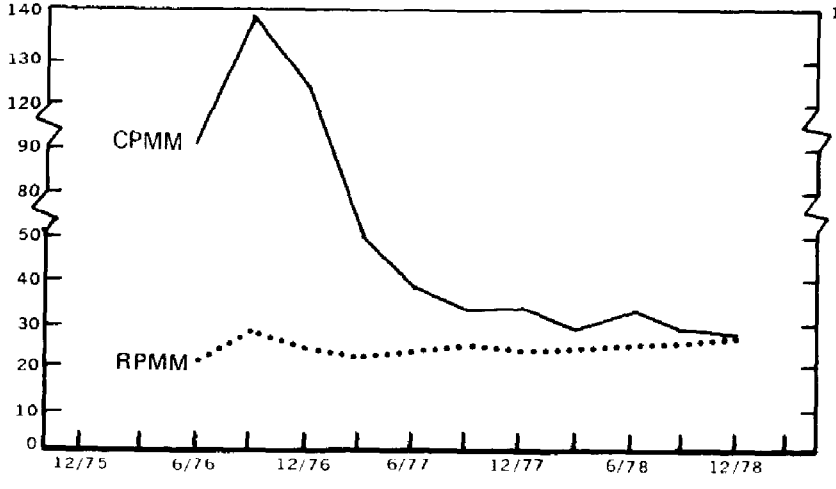


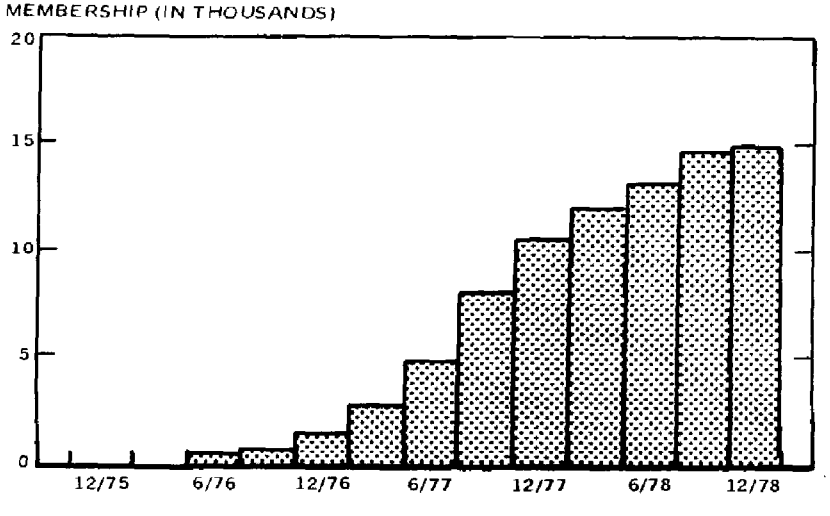
APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

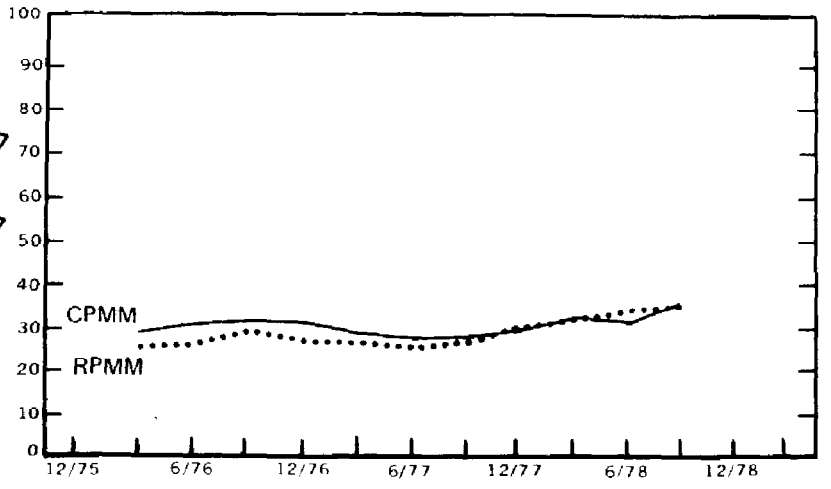
(SEE NOTES ON PAGE 69)

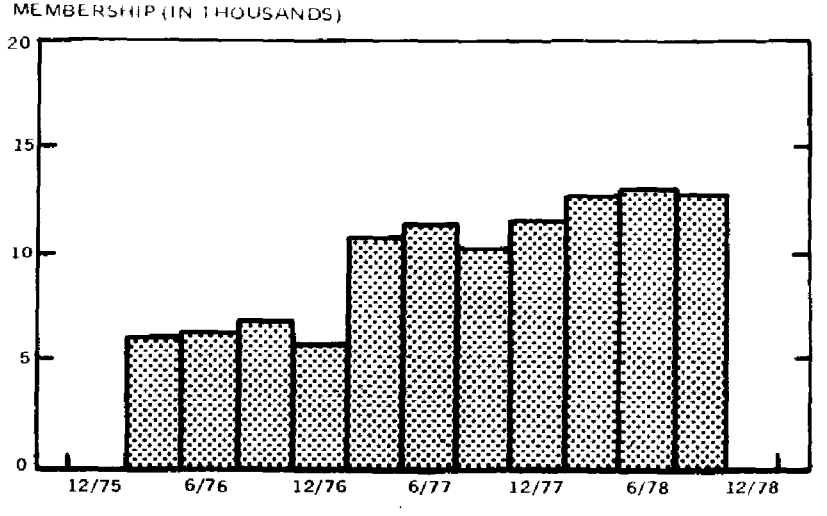
HMO 7





HMO 8



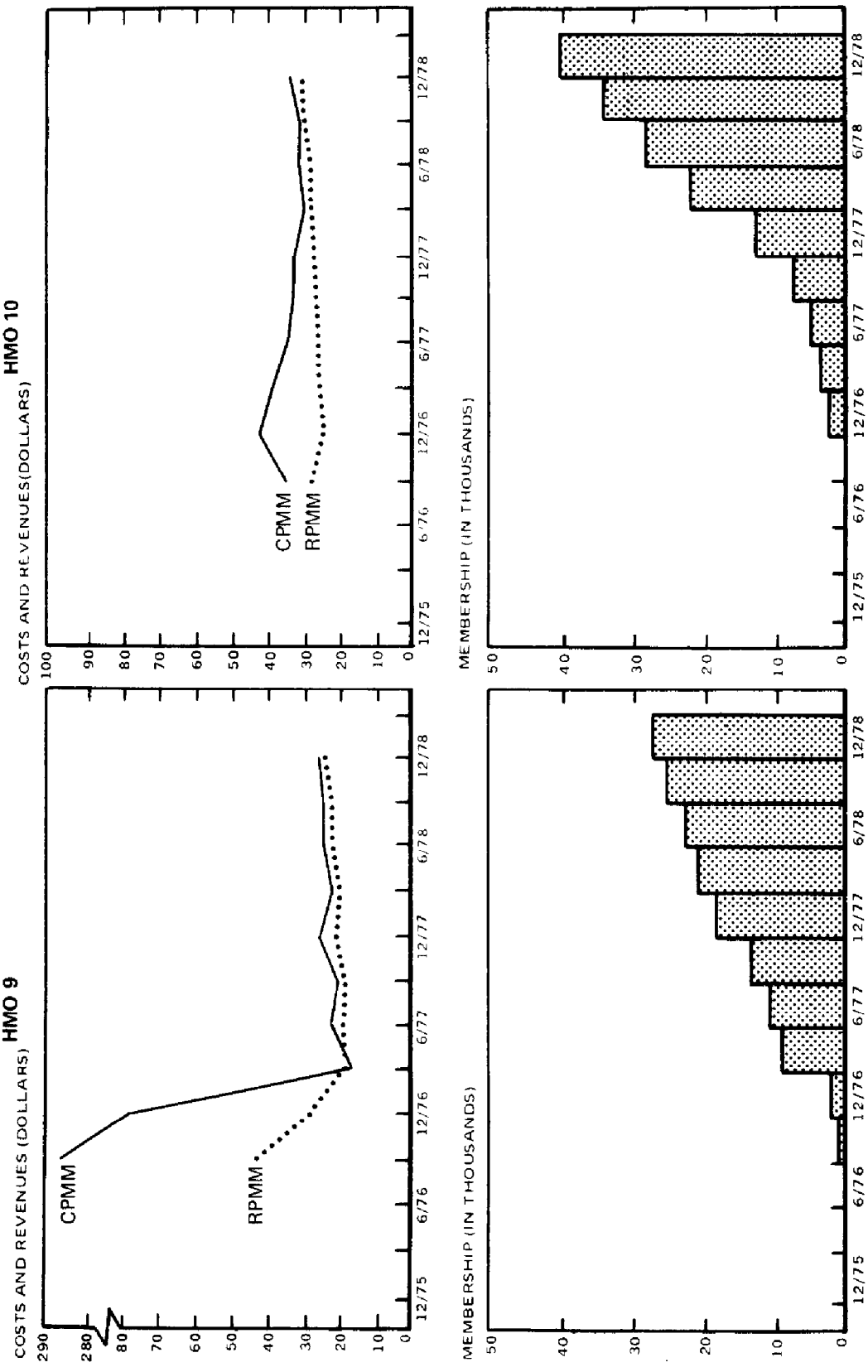


APPENDIX IV

APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

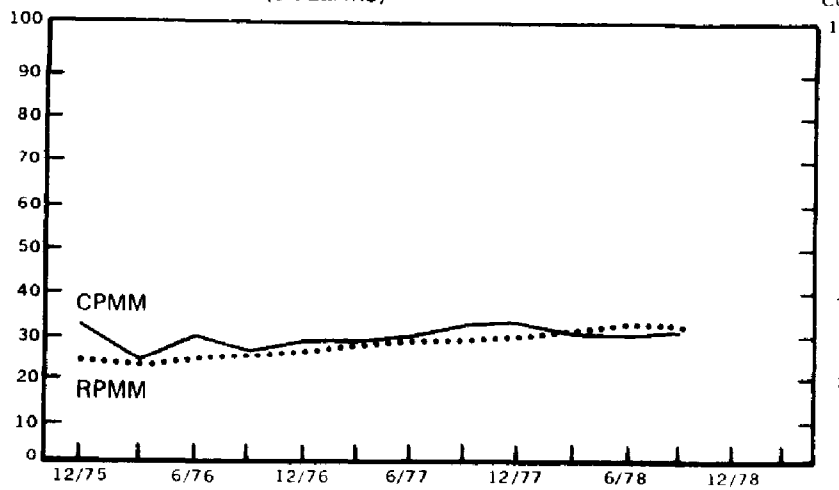
(SEE NOTES ON PAGE 69)

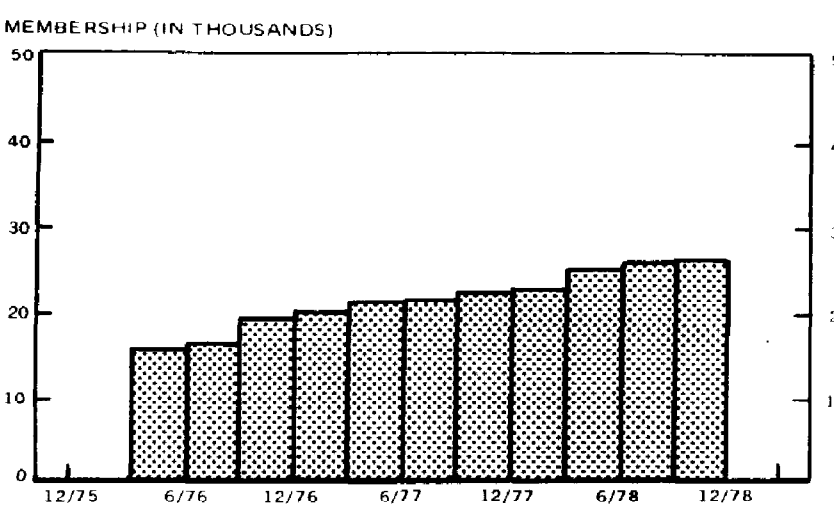


QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

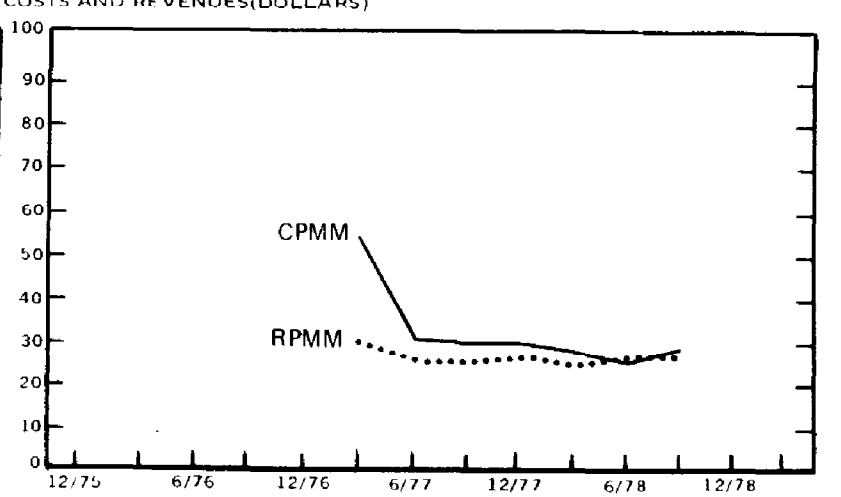
(SEE NOTES ON PAGE 69)

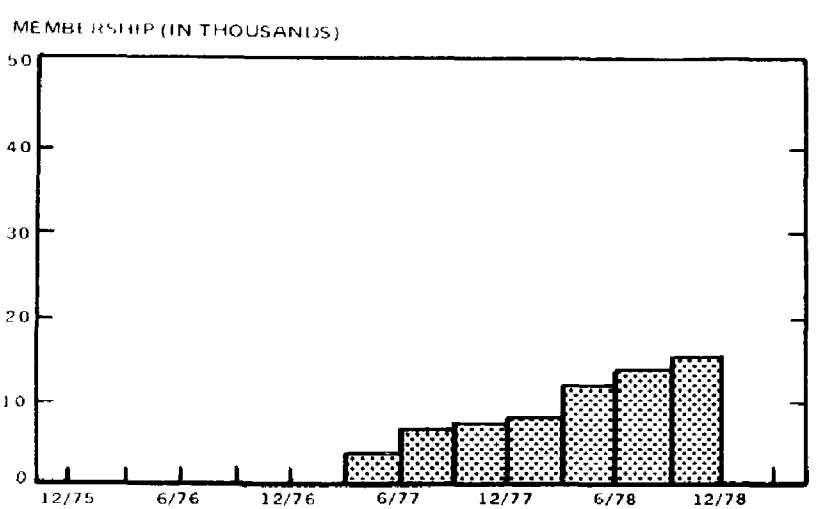
HMO 11





HMO 12



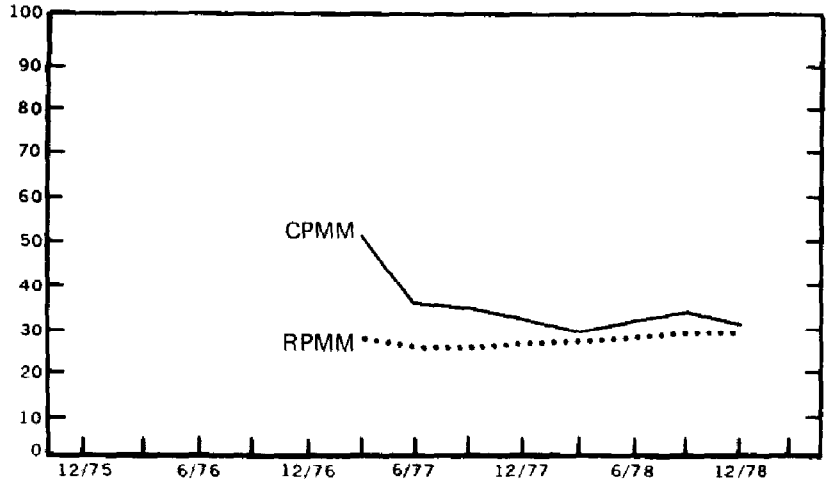


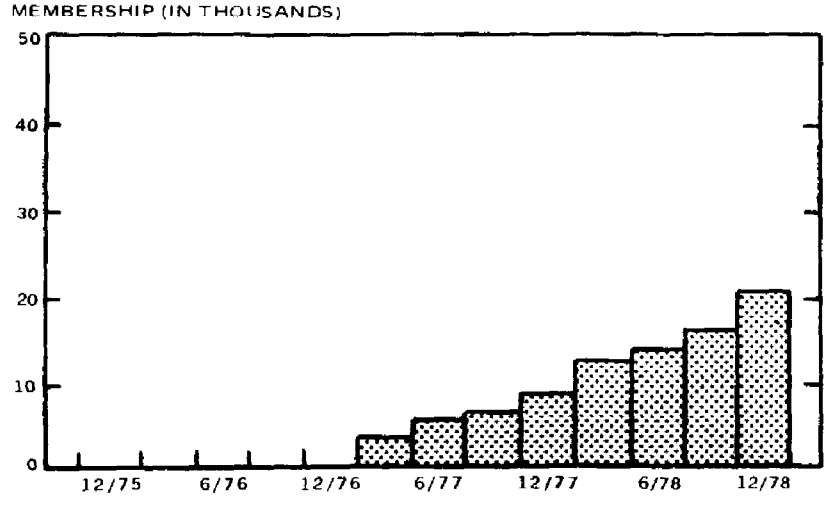
APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

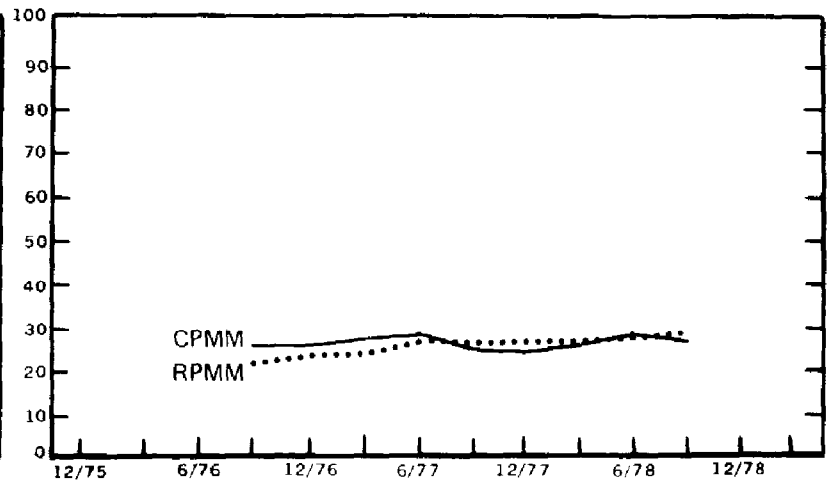
(SEE NOTES ON PAGE 69)

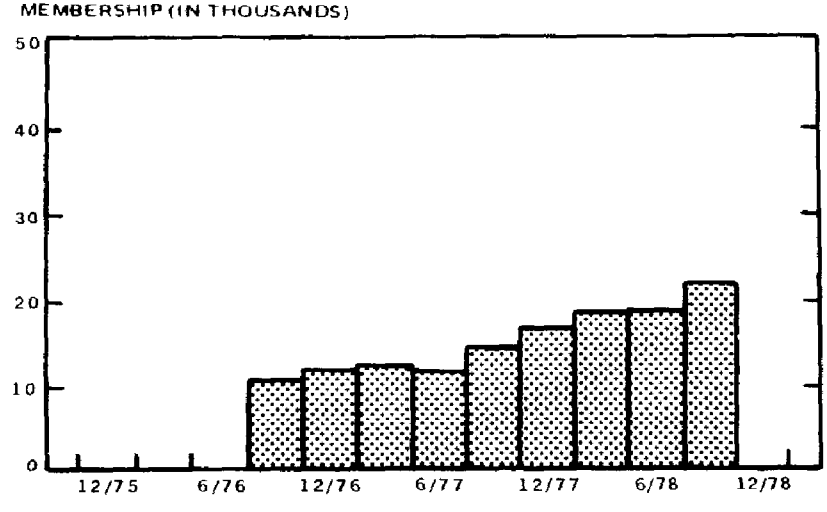
HMO 13





HMO 14



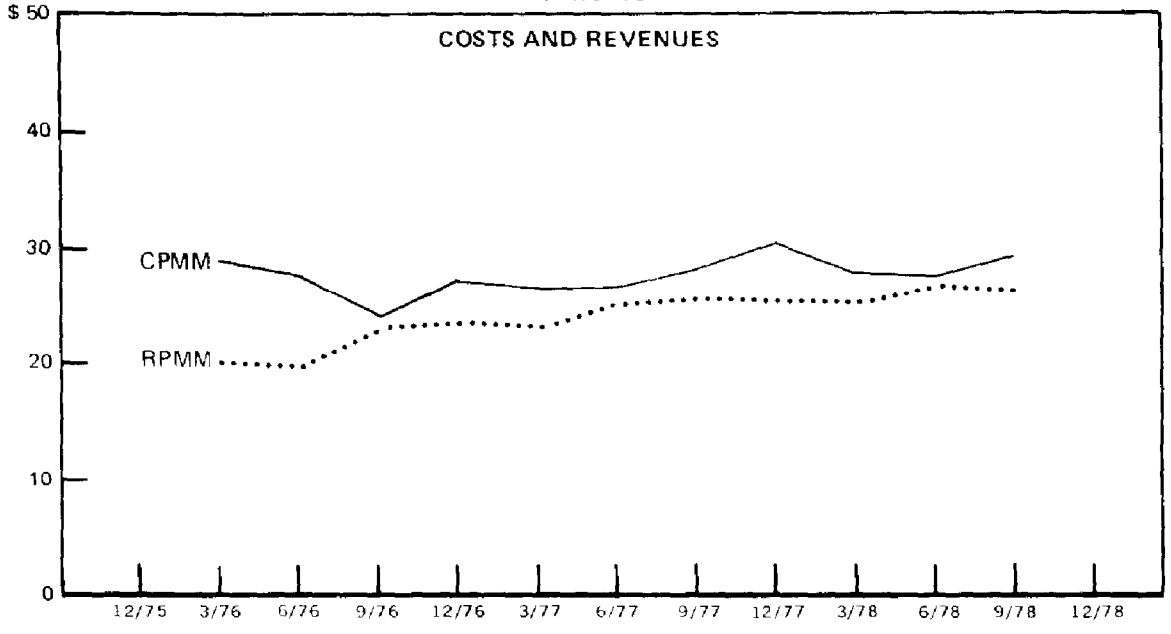


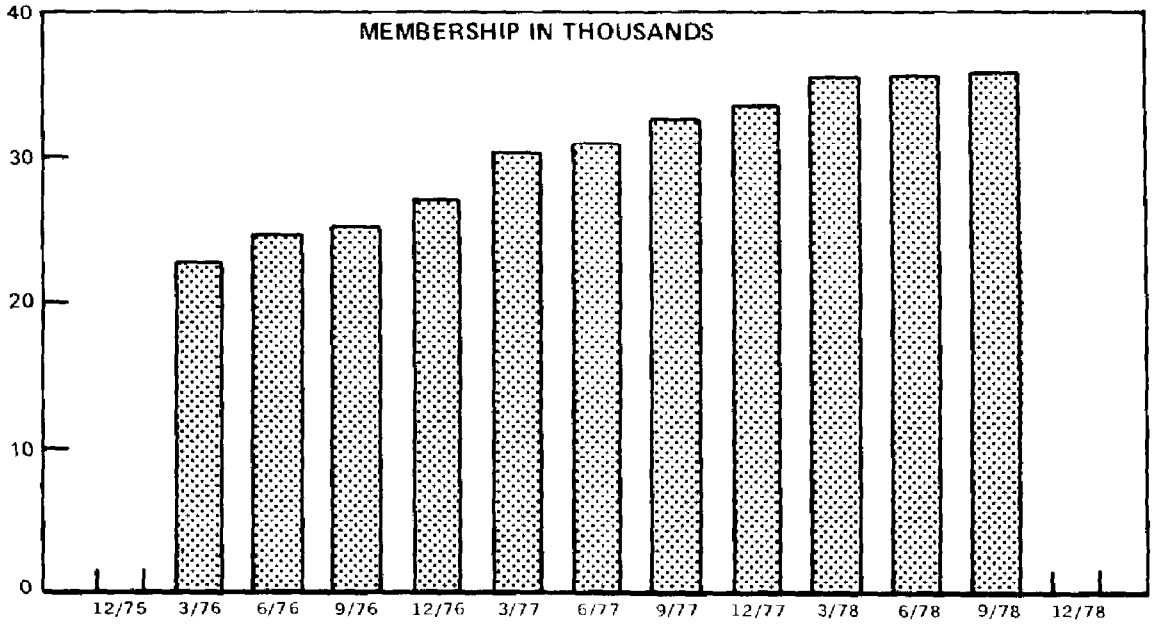
APPENDIX IV

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A GOOD CHANCE TO ACHEIVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 69)

HMO 15





QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

NOTES

1. Cost, revenue, and membership data are based on data from unaudited quarterly reports submitted by HMOs to HEW under the HMO National Data Reporting Requirements (OMB No. 68R-1496).

2. CPMM = cost per member month.

3. RPMM = revenue per member month.

4. CPMM and RPMM for HMO 17 are about $49 and $31, respectively, for the quarter ending 12/31/78.

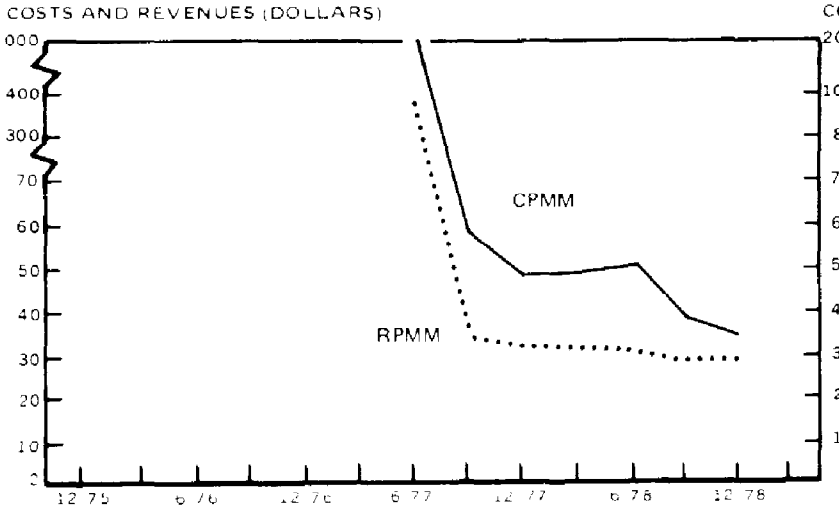
5. For HMO 18 premium per member month (PPMM) is used because revenue per member month (RPMM) included a large amount of grant funds in recent quarters.

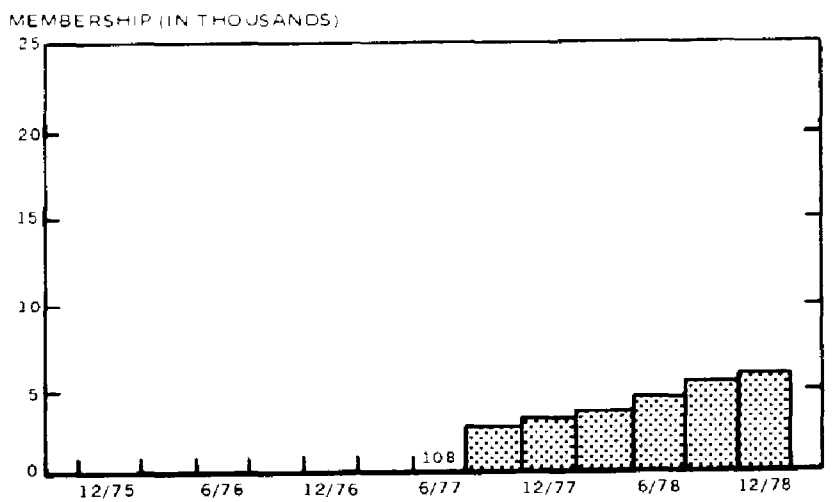
6. CPMM and RPMM for HMO 24 are about $59 and $33, respectively, for the quarter ending 9/30/78.

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

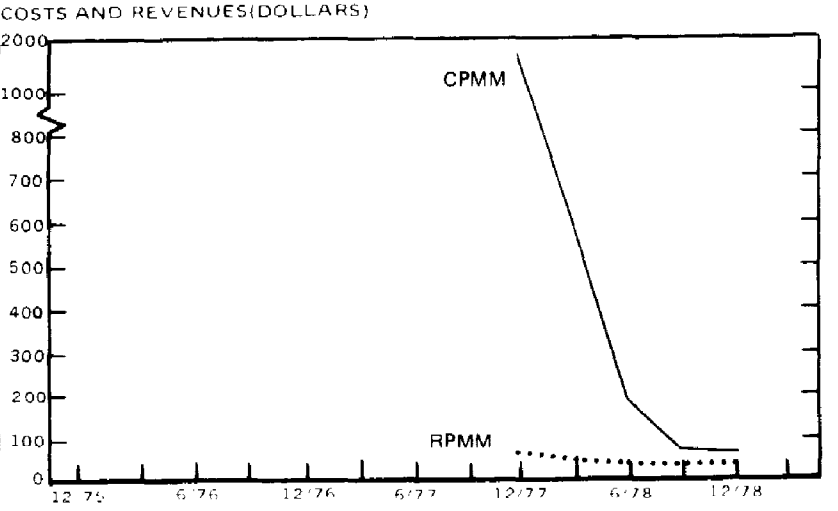
(SEE NOTES ON PAGE 78)

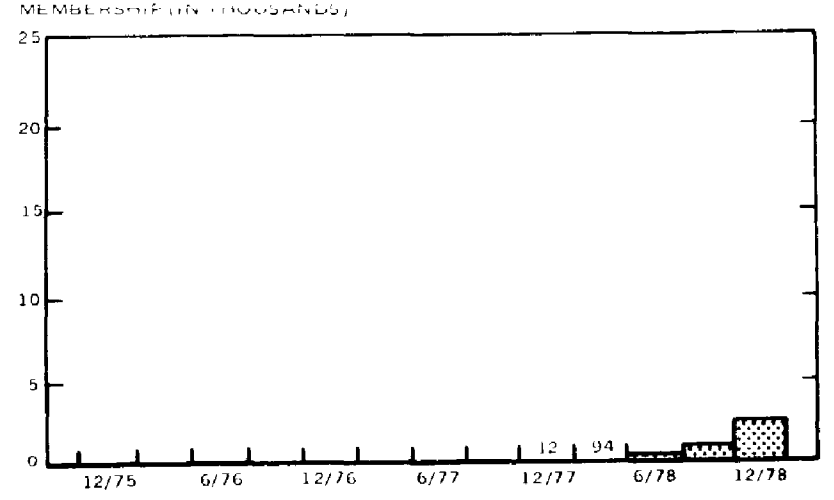
HMO 16





HMO 17





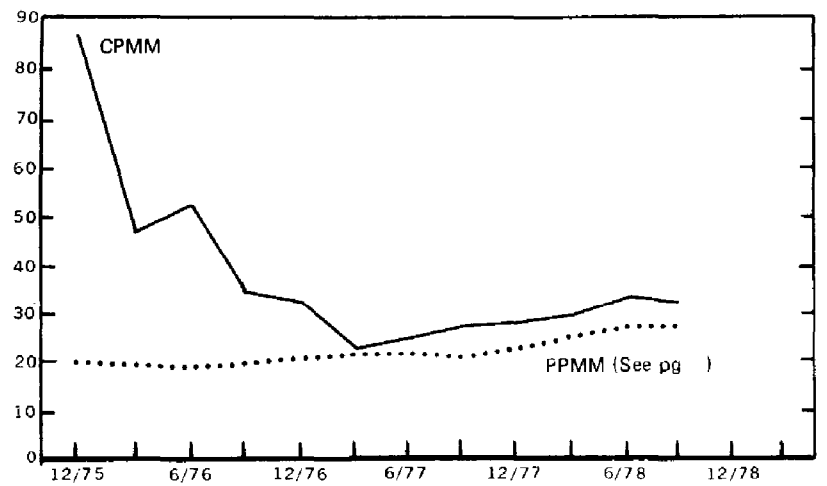
APPENDIX V

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

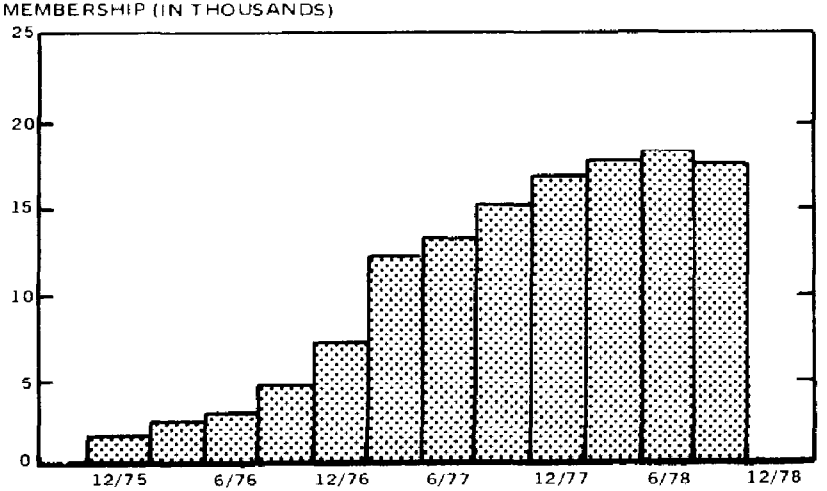
(SEE NOTES ON PAGE 78)

HMO 18

COSTS AND REVENUES (DOLLARS)

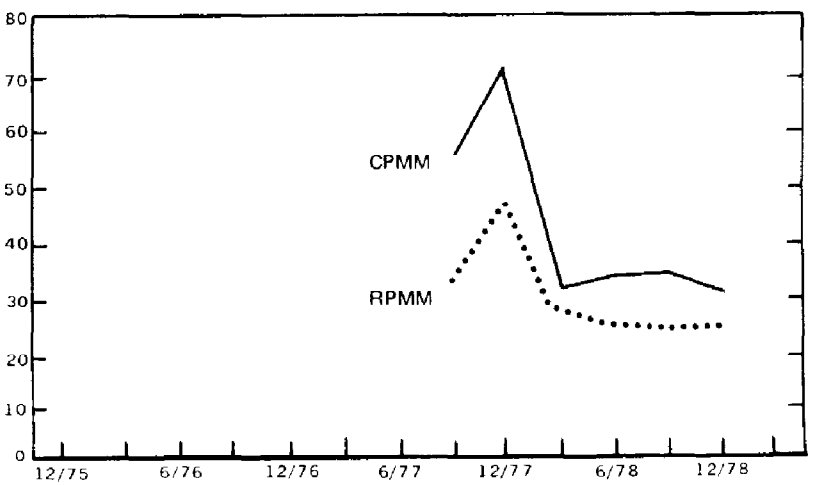


MEMBERSHIP (IN THOUSANDS)

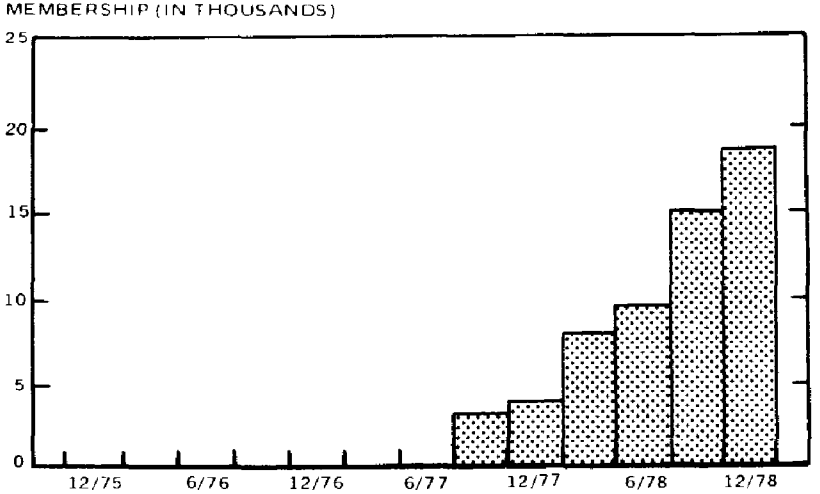


HMO 19

COSTS AND REVENUES(DOLLARS)



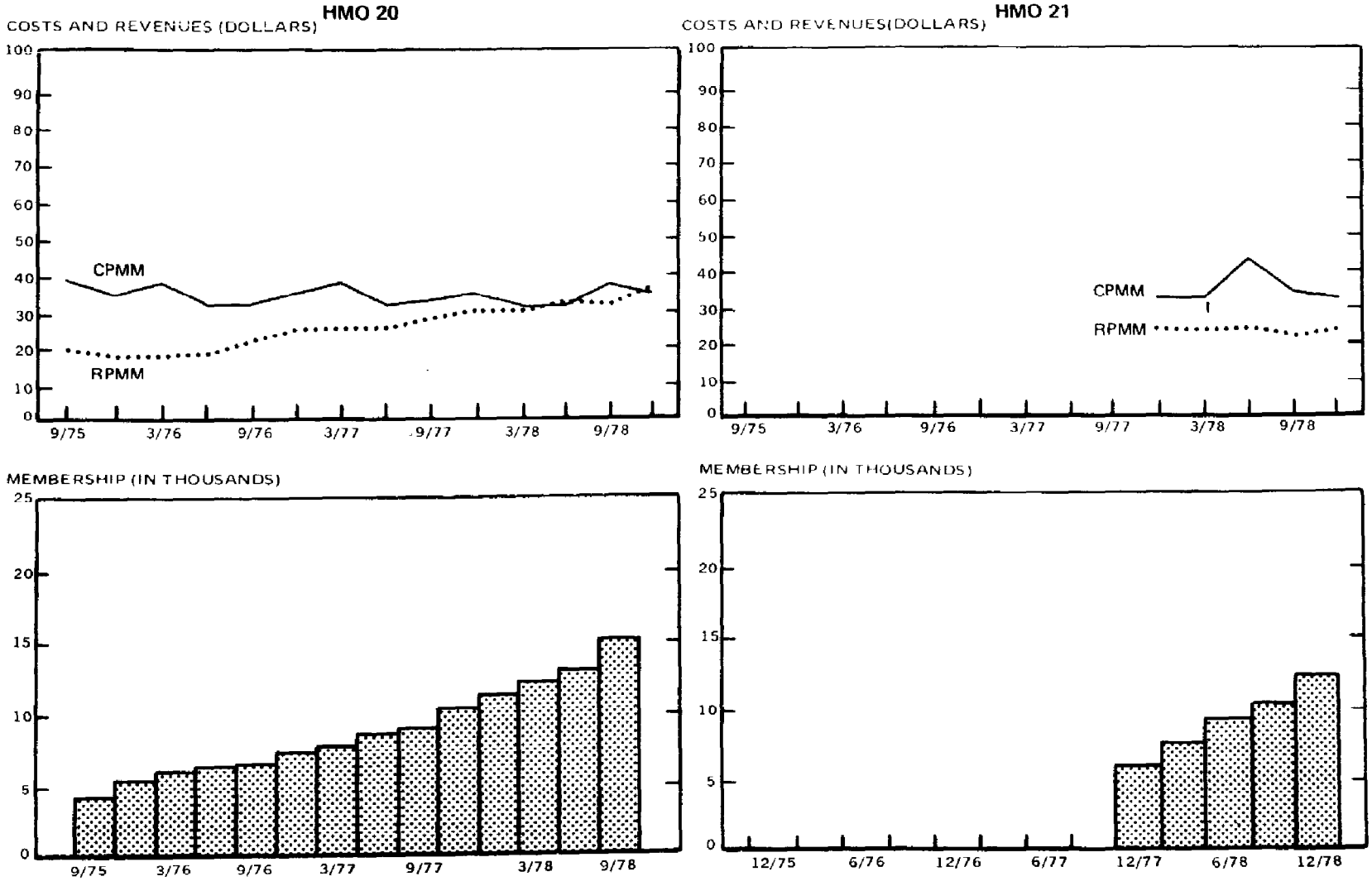
MEMBERSHIP (IN THOUSANDS)



APPENDIX V

QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 78)



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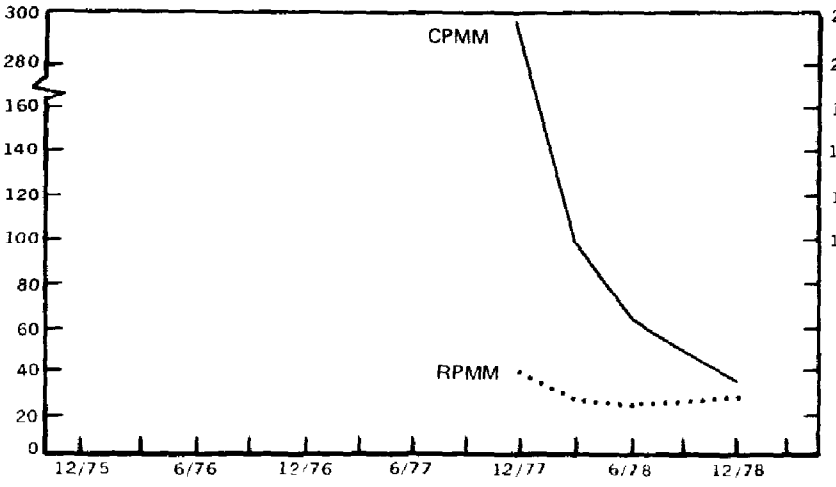
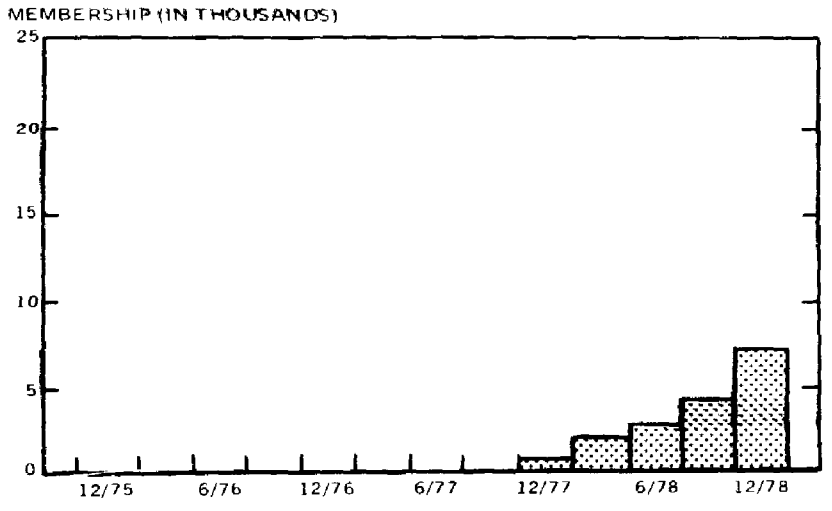
QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

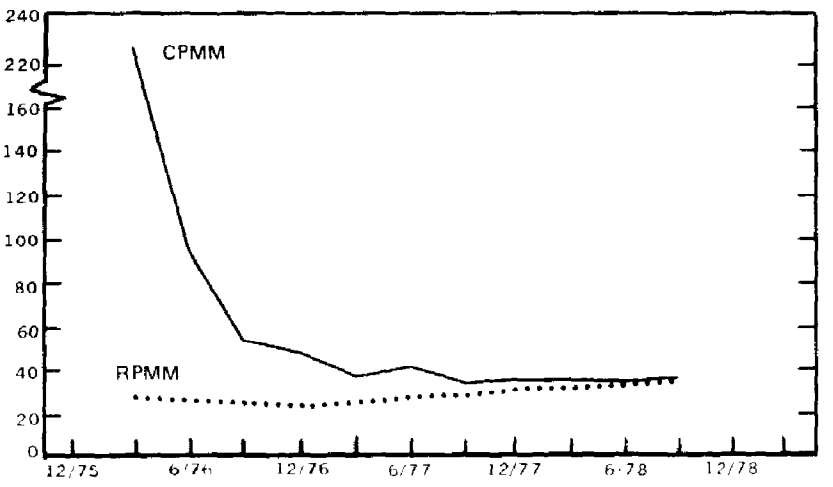
(SEE NOTES ON PAGE 78)

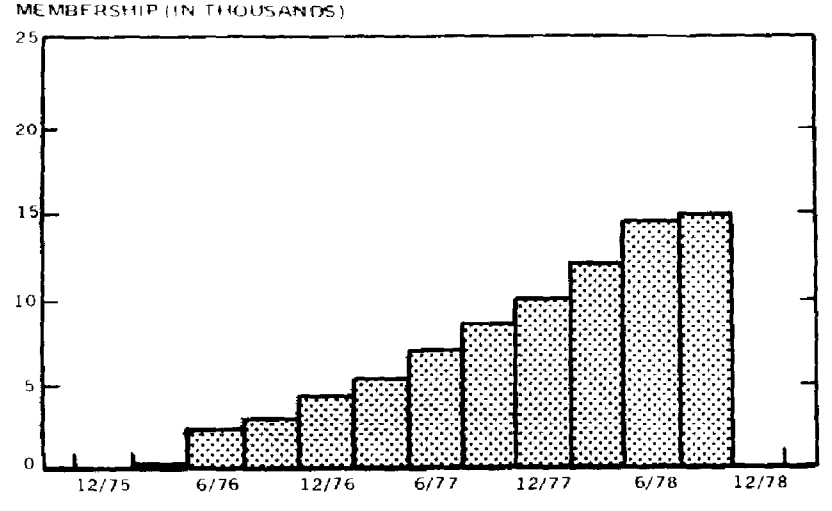
HMO 22





HMO 23





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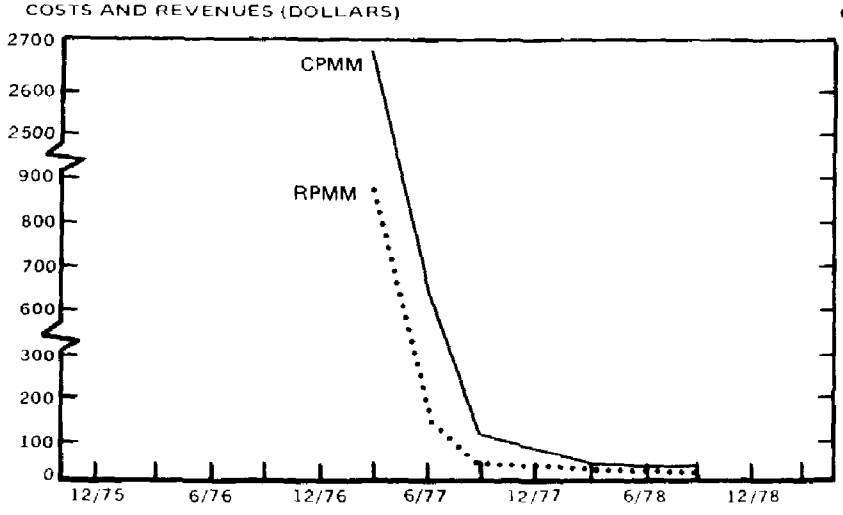
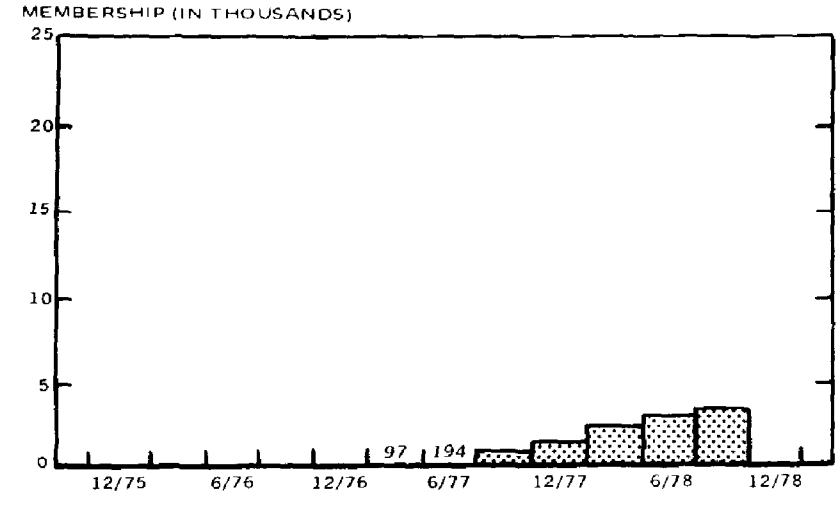
QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 78)

HMO 24





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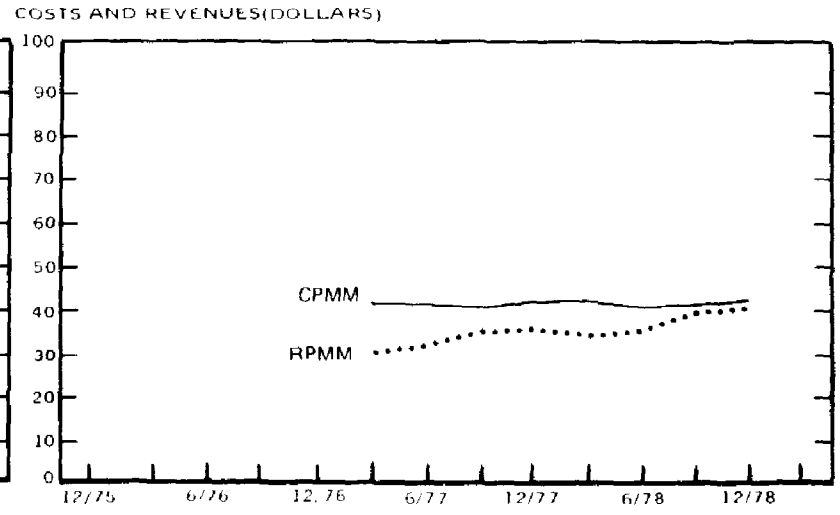

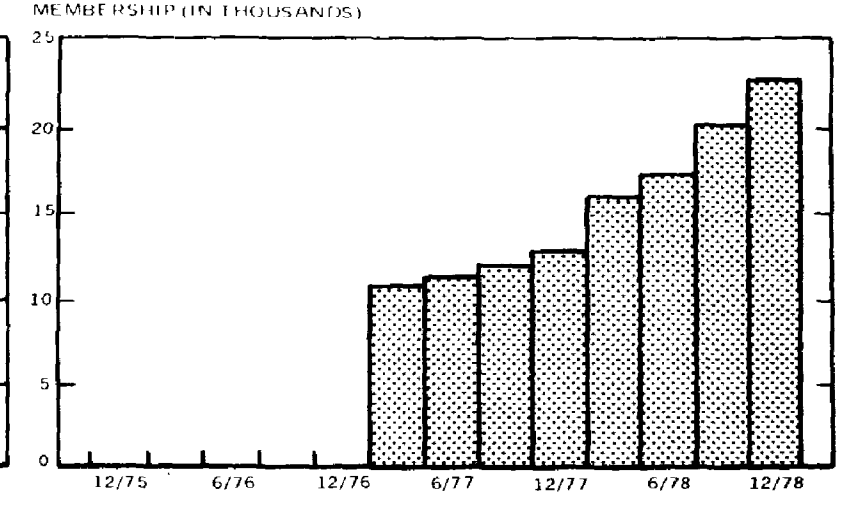

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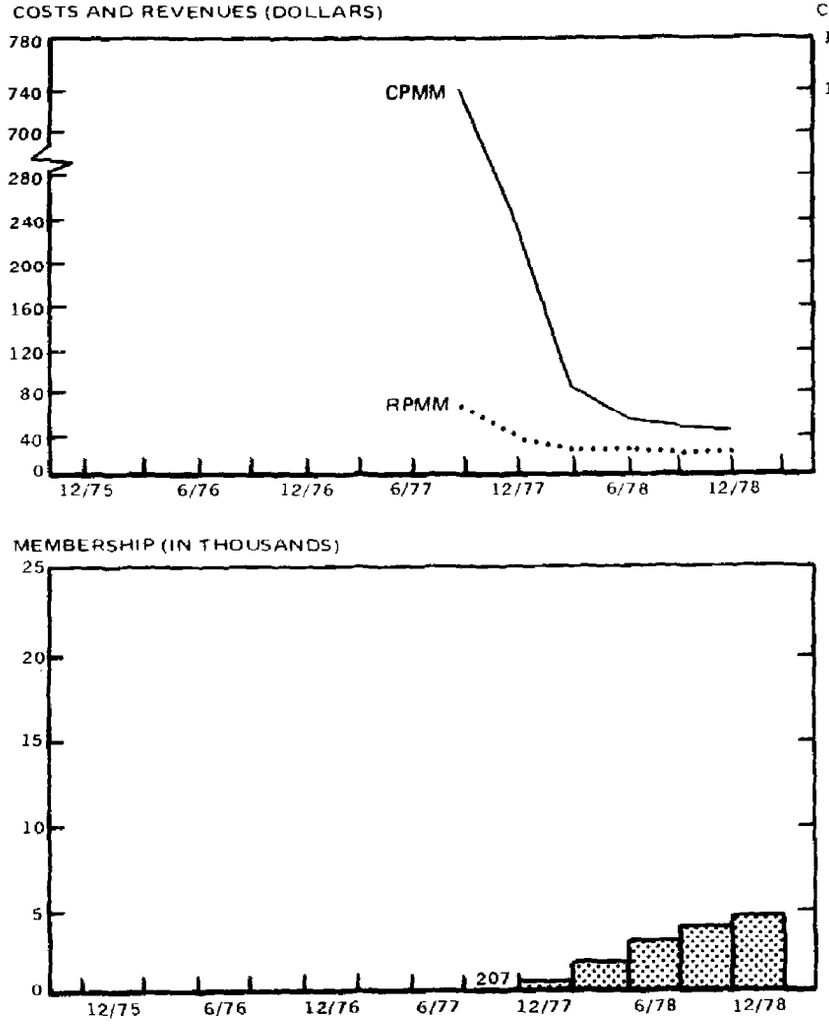
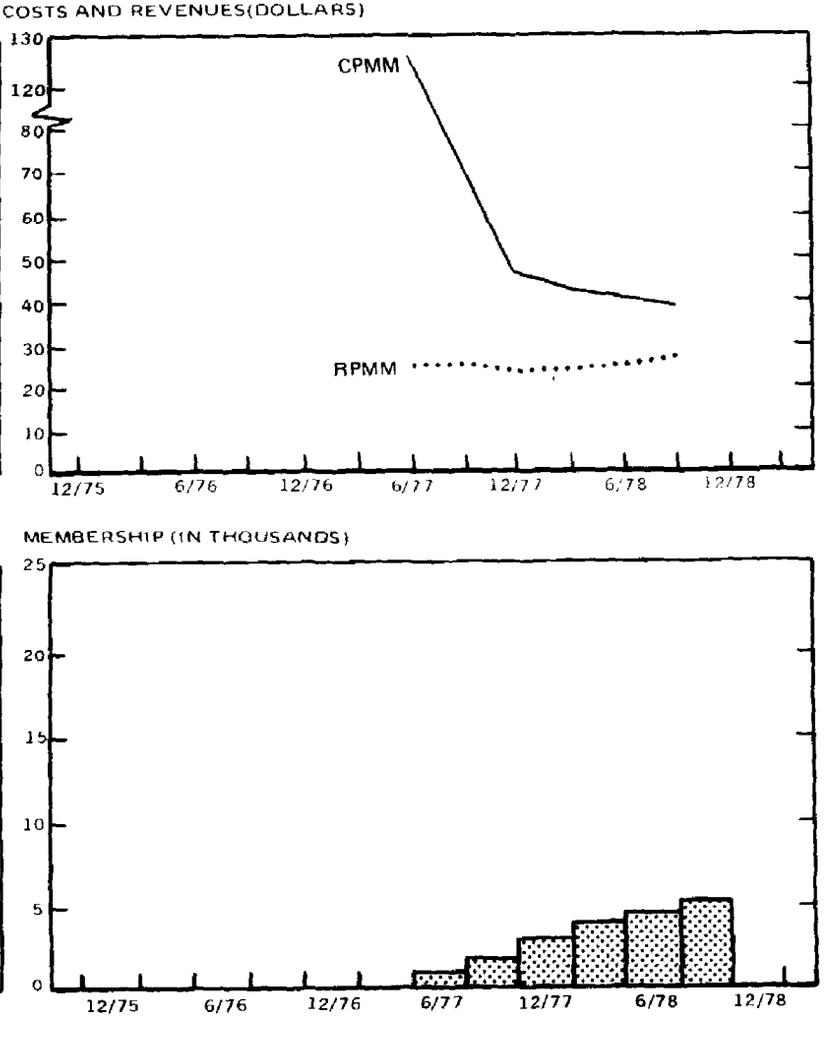
QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 78)

HMO 26



HMO 27



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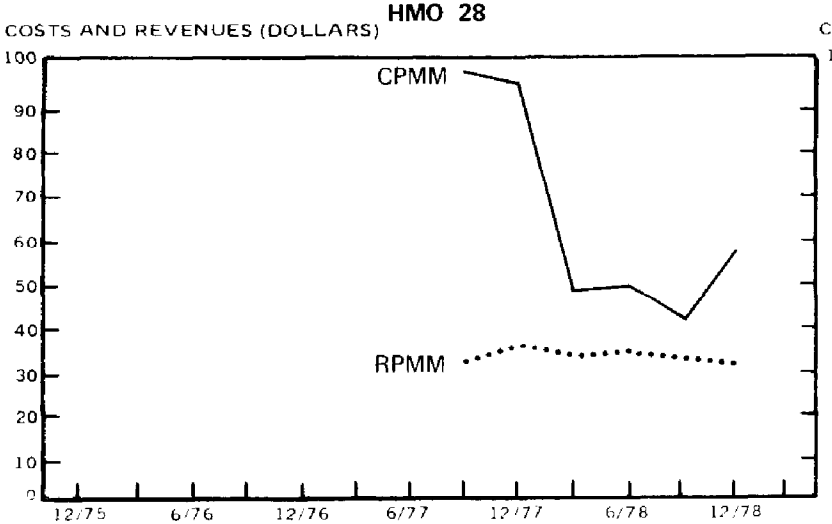
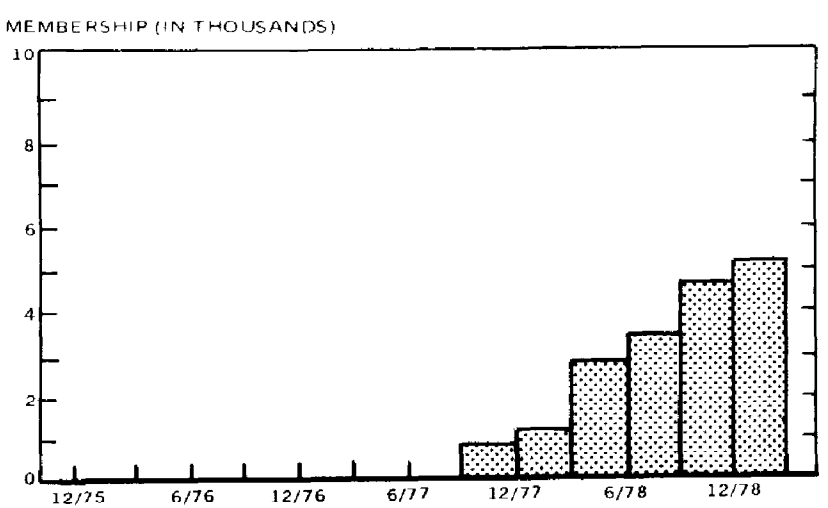
QUARTERLY COST, REVENUE, AND MEMBERSHIP EXPERIENCE OF HMOs WITH A FAIR OR POOR CHANCE TO ACHIEVE FINANCIAL INDEPENDENCE

(SEE NOTES ON PAGE 78)

HMO 28





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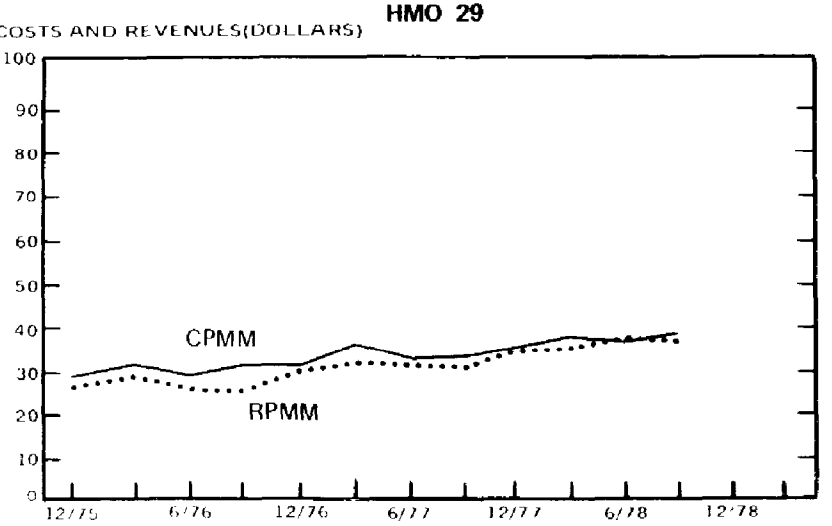

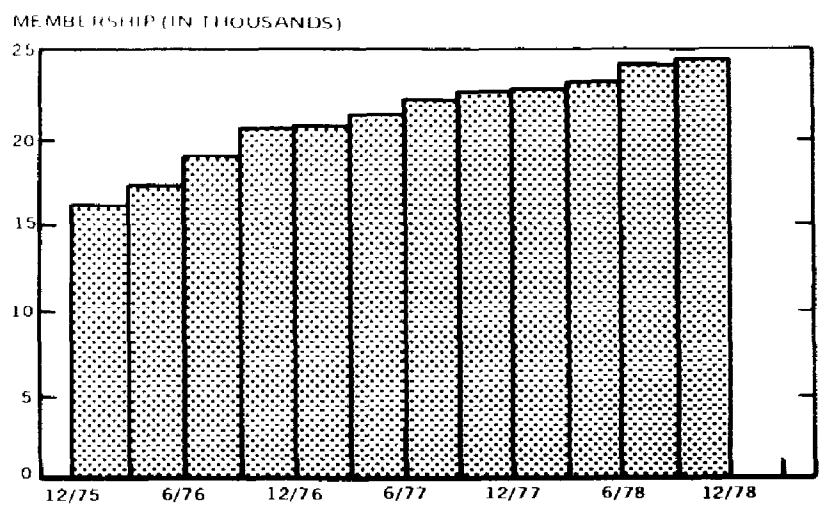

APPENDIX V

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

APR 23 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report "HMO Act Provides for Adequate Financial Assistance but HEW Needs to Improve HMO Program Policies and Procedures."

The requested comments are enclosed. Due to the short time in which we had to respond to your request we were not able to develop and coordinate these comments as fully as we normally do. Hence, they may be modified or revised when we comment on the final report.

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

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "HMO ACT PROVIDES FOR ADEQUATE FINANCIAL ASSISTANCE BUT HEW NEEDS TO IMPROVE HMO PROGRAM POLICIES AND PROCEDURES"

GENERAL COMMENTS

The Department is pleased to note that the General Accounting Office (GAO) has recognized that substantial progress has taken place in the management of the Health Maintenance Organization (HMO) program, especially as it relates to the deficit loan program, the grant assistance program and the compliance program. However, we also would like to note progress not specifically mentioned in the report, including: the promulgation of guidance and the development of monitoring systems for feasibility, planning and initial development (ID) grants; implementation of a loan monitoring activity at the regional level; and the development of draft pre-qualification guidelines.

Further, the Cover Summary and the Digest should be more balanced and reflective of the chapter narratives. Significant conclusions are reached by GAO which should be included in the Digest. These are:

(A) "HEW has made progress toward publishing formal, uniform operating deficit loan policies, formulating and issuing regulations and policy guidance for the ambulatory health care facility loan program and improving the Loan Branch's staffing situation."

(B) "As of March 1, 1979, OHMO had made significant improvements in the compliance program by (1) issuing compliance regulations, (2) publishing an HMO compliance plan, which outlined the compliance program's functions, procedures, organization, and staffing, and (3) developing a computerized management information system to summarize performance data on HMOs and provide the basis for an "early warning" system that would, among other things, monitor the financial soundness of HMOs. Also, the Compliance Division's staff had been expanded significantly."

(C) "In October 1978, OHMO's Division of Development set in motion plans to:

(1) update grant guidelines and standards for reviewing feasibility and planning grant applications;

(2) prepare initial development grant review standards which never existed before; and,

(3) define a grantee monitoring system.

The division also instituted a system for informing regions about grant policy decisions."

GAO RECOMMENDATION

We recommend that the Secretary of HEW establish a development strategy for new HMOs which guides an HMO to plan only for enough staff and facilities to enroll and serve about 8,000 to 10,000 members during the initial stage of operation. After the HMO's costs per member become relatively constant, OHMO should determine whether the subscriber rates which the HMO needs to break even are competitive in the local market. If not, the HMO should not expand its capacity. If the HMO's membership decreases significantly at the higher rate levels, the HMO may not be able to continue operating.

Under this strategy, an HMO's first Federal loan to finance operating losses should not exceed the amount necessary to enroll and serve about 8,000 to 10,000 members. As soon as the HMO's operating experience demonstrates it is a viable business entity, additional loans could be made to finance expanded operations.

DEPARTMENT COMMENT

We find the analysis both informative and useful. It will create a bench mark for our early warning system and direct us to begin focusing on the use of revenues when an HMO first begins to show a leveling off of costs. At that time a more indepth financial analysis will be undertaken and if necessary, corrective action will be mandated.

Nevertheless, we cannot concur with the recommendation that funding be considered only for an organization with enrollment levels of 8,000 to 10,000 members. First, we are concerned that the analysis may not be sufficiently complete to warrant endorsing it as a guide for future HEW actions. Secondly, we do not feel that the recommendation to focus the planning of an HMO to an enrollment level of 8,000 to 10,000 necessarily limits the government's financial risk. Thirdly, the requirement could increase the government's risk since the stopping of loan funds in an arbitrary manner could inadvertently interrupt well planned and smoothly integrated patterns of growth. In the period it would take to review the advisability of a second loan, the interruption in loan funds could cause the HMO to slip back to a position more adverse than if it had been allowed to continue with its planned growth.

Further, if some HMOs were forced to price premiums to cover costs at an 8,000 to 10,000 membership level, they would face serious competitive disadvantages. Equally important, an arbitrary cutoff of loan funds at the 8,000 to 10,000 member level could inadvertently injure HMOs whose growth patterns require a larger population to reach a leveling off effect. In this case HMOs on the road to viability could be made artificially inviable and for no apparent beneficial purpose. For these reasons, the implementation of GAO's proposal could have a negative affect on HMO development.

The charting technique used by GAO gives the impression that there is not much difference in the costs of HMOs beyond a membership level of 8,000. Significant differences are apparent from reformatting Chart A, on page 10 of the GAO report as follows:

Cost Per Member Per Month

Membership Level	Approximate Sample Size	Low	High	Difference	% Difference
8,000 to 10,000	20	17	47	30	176
20,000 to 22,000	13	23	42	19	82
75,000	3	25	35	10	40

The range of difference shown above is 40 to 176 percent. The implications of these differences on the rates and operations of an individual HMO are great. Of course, the sample size is very small and the costs shown cover a time period which has been inflationary. These factors further reduce the reliability of this analysis.

Furthermore the GAO analysis does not adequately consider one of the basic objectives of rate setting: financial breakeven. Revenue is derived from the rate multiplied by the number of member contracts. Costs are analyzed as being fixed and variable. Rates are set to yield a sufficient contribution (the difference between revenues and variable expenses) to cover fixed costs at a given level of membership. The original rates may be inadequate because projections differ for several reasons. For example: (1) a different contract mix (singles, couples, families); (2) a different number of members per contract, etc. For these reasons the complexity of each case demands a thorough analysis. The examples cited by GAO prove this point.

We agree, that an HMO should not underprice its premium just to increase its membership. However, there are certain situations in which exceptions may be justified. For example, initial entry into a tight market may justify short run price reduction. HMOs are complex organizations that operate in very different environments; each must have its own rate setting strategy. Each HMO must be dealt with on an individual basis.

Pricing is important but cannot be considered by itself to be the most significant variable as a determinant of future financial viability. We have found in numerous instances that significant actions are usually available to management (e.g., reducing hospital use, medical referrals, etc.) to enable them to continue reducing variable costs. More importantly, in a number of instances we have found that fixed costs including staffing can be substantially reduced when necessary and desirable.

For the above reasons, it would be our position that the GAO analysis be utilized as a significant monitoring bench mark for determining appropriateness of further utilization of loan funds, but not as an arbitrary loan limitation requirement.

GAO RECOMMENDATION

That the Secretary of HEW

--assure that sufficient staff is available to complete work on the operating deficit loan policy and regulations and policy guidance for the ambulatory health care facility loan program, and that sufficient priority is given to these projects throughout the Department so that they can move quickly through required review levels.

DEPARTMENT COMMENT

We concur that issuance of the operating deficit loan policy and both regulations and policy guidance for the ambulatory health care facility loan program is being given top priority. Over the past year, we have increased the number of staff in the Loan Branch. This increase has allowed OHMO to work on the necessary loan policy documents. We believe that work on these projects is proceeding well and feel confident that we can meet most of the target deadlines.

Approximately 80 percent of the operating deficit loan policy manual has been completed by the Department. These completed policies include loan monitoring, defaults and remedies, and general provisions applying to direct loans and loan guarantees. The remaining 20 percent of the loan manual has been drafted and is in the process of final clearance. We anticipate completion of the entire operating deficit loan policy manual by the June 30 deadline.

Interim regulations and policy guidance for ambulatory health care facility programs are scheduled to be completed by July 31 and not March 30 as GAO reported. A draft of these regulations has recently been completed.

GAO RECOMMENDATION

--assess the impact of the ambulatory health care facility loan program on the Loan Branch's staffing and assign additional staff to the branch in a timely manner, so that maximum efficiency can be expected at the start of the new program.

DEPARTMENT COMMENT

We concur that the implementation of the ambulatory facility loan program will require supplemental staff for the Loan Branch. We have assessed the impact of the anticipated workload and additional positions have been approved.

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We project that about 25 HMOs will apply for an ambulatory facility loan in FY 1980. Although the GAO report is consistent with this estimate with a projection of 29 HMOs requesting assistance, we are not convinced, that half of these HMOs will simultaneously submit more than one application, as suggested in the GAO report. However, if this is the case, much of the programmatic review work can satisfy the review requirements for both facilities. In other words, the workload does not double if the same HMO submits two applications simultaneously.

The Department has requested 9 additional positions for the OHMO program in FY 1980. Three of the positions are targeted for the Loan Branch. Additional positions will be reallocated for this function if the need arises.

GAO RECOMMENDATION

--carefully monitor efforts to obtain HMO reports in a more timely fashion.

DEPARTMENT COMMENT

We concur with the recommendation. As recognized, we have made significant progress in implementing our newly organized compliance monitoring process. For the next six months, our staff is concentrating on fine tuning the systems. This includes tightening the procedures for controlling the receipt of quarterly reports from HMOs. Since implementing the "tickler" system in December, we have sent 26 notices warning HMOs of regulatory compliance action if their reports were not submitted within 15 days. A notice of noncompliance and default was issued to one HMO when reports were not received. This was subsequently remedied. The remaining 25 HMOs complied within 15 days with their submission.

GAO RECOMMENDATION

--assess the impact of an increasing workload on the staffing in the HMO Compliance Branch so that additional staff can be assigned promptly, if required.

DEPARTMENT COMMENT

We concur with the recommendation. Our newly organized compliance monitoring process and the computerized early warning system will increase the staff's efficiency in handling the monitoring workload. An effort will be undertaken in the next four to six months to quantitatively measure the impact that the new monitoring process and computer system will have on staff efficiency. We then should be able to determine the most appropriate staffing ratios for compliance monitoring once the impact of the new systems are fully

APPENDIX VI

known. We believe that currently the present staff assigned to this function is adequate. If the evaluation concludes that additional staff is needed, we will reallocate staff or request authorization for additional positions.

GAO RECOMMENDATION

-- assure that priority is given to validating HMO report data, completing a summary of compliance policy and procedures in order to assure uniformity, and rendering a decision on regional responsibilities.

DEPARTMENT COMMENT

We concur with the recommendation. Priority for these activities has already been established to continuously improve our capability of validating the HMO report data. Manual checks are now performed to verify the mathematical and logical consistency of the quarterly reports. This will be transferred to a computerized check by the end of FY 1979. OHMO is progressing in writing programs for verifying all data submitted by an HMO throughout the year against their annual audited statements.

During the next nine months a structured OHMO policy and procedures manual will be developed. This will include qualification review guides now being site tested. Procedures are being developed to maintain a routine issuance process.

A decision has been made to maintain a centralized compliance activity. We are evaluating what the future role of the Regional Offices may be in carrying out compliance responsibilities and expect to make a final decision before the end of the fiscal year.

GAO RECOMMENDATION

We recommend that the Secretary of HEW assure that OHMO proceeds as quickly as possible with its plans to publish qualification guidelines and to develop improved grant program guidance which can establish more clarity and uniformity in the program.

DEPARTMENT COMMENT

We concur with this recommendation. We agree that it is important for us to publish qualification guidelines and to improve grant program guidance. We have taken several steps in the past year to carry out this recommendation. These includes:

- The development of review standards for feasibility, planning and initial development grants and for an ID monitoring visit prior to application for qualification. These standards are designed to review the major areas of development of an HMO at each level of funding. The ID monitoring review standards are the same as those used during the qualification review. All of these standards should be completed by early June.

- The development of policy issuances and program management bulletins to advise regional office staffs and grantees of new policy or existing policy.

- The initiation of training for regional office personnel and grantees on Management Information Systems.

- The development of contract proposals to update the Feasibility Planning Manual.

The development of grant guidelines and policy guidance will continue to be a priority of the OHMO .

(102039)