United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

October 2002

MEDICARE+CHOICE

Selected Program Requirements and Other Entities' Standards for HMOs

GAO-03-180

Contents

Letter

1

Results in Brief 4
Background 5
Selected M+C Requirements for HMOs 10
Selected FEHBP Requirements for HMOs 13
Selected NAIC, JCAHO, and NCQA Requirements for HMOs 15
Comments from CMS and the Other Entities 16

Appendixes

Appendix I: Benefit Package Proposals 18

Appendix II: Beneficiary Enrollment 28
Health Plan Enrollment Opportunities for M+C and FEHBP Beneficiaries 34

Appendix III: Marketing and Enrollee Communication Materials 37

Appendix IV: Quality Improvement 54

Appendix V: Comments from the Centers for Medicare & Medicaid Services 77

Tables

Table 1: Selected Requirements for Benefit Package Proposals, M+C and FEHBP 20
Table 2: Selected Requirements for Beneficiary Enrollment in HMOs, M+C and FEHBP 29
Table 3: Opportunities for Medicare Beneficiaries to Enroll in an M+C Health Plan or Make Health Plan Changes Under M+C's Lock-in Provision 35
Table 4: Opportunities for FEHBP Beneficiaries to Enroll in a Health Plan or Make Health Plan Changes 36
Table 5: Selected Requirements for Marketing and Enrollee Communication Materials, M+C, FEHBP, NAIC, JCAHO, and NCQA 39
Table 6: Selected Requirements for Quality Improvement for M+C, FEHBP, NAIC, JCAHO, and NCQA 57

Figures

Figure 1: Timeline for Submission, Review, and Approval of HMOs' Benefit Package Proposals for Benefit Year 2001 26
Figure 2: Timeline for Submission, Review, and Approval of HMOs' Benefit Package Proposals for Benefit Years 2003 Through 2005 27

Abbreviations

AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
ACR	adjusted community rate
ACRP	adjusted community rate proposal
BBA	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAHPS	Consumer Assessment of Health Plans
CHCD	clinical health care disparities
CLAS	culturally and linguistically appropriate services
CMS	Centers for Medicare & Medicaid Services
EGHP	employer group health plan
ESRD	end-stage renal disease
FAR	Federal Acquisition Regulation
FEHBP	Federal Employees Health Benefits Program
FFS	fee-for-service
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HMO	health maintenance organization
HOS	Health Outcomes Survey
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
M+C	Medicare+Choice
M+CQRO	Medicare+Choice quality review organization
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
OIG	Office of Inspector General
OPM	Office of Personnel Management
PBP	plan benefit package
PFFS	private fee-for-service
PPO	preferred provider organization
QAPI	quality assessment and performance improvement
QI	quality improvement
QIO	quality improvement organization
QISMC	quality improvement system for managed care
SSSG	similarly sized subscriber groups
VAIS	value-added items and services

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

October 31, 2002

The Honorable Nancy L. Johnson
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Madam Chairman:

Since the early 1980s, health maintenance organizations (HMO) have entered into risk-based contracts with Medicare and offered beneficiaries an alternative to the traditional fee-for-service (FFS) program.[1] By 1997, approximately 5.2 million Medicare beneficiaries (14 percent) were enrolled in an HMO.[2] Although Medicare HMOs were available in most urban areas, they were often unavailable in rural areas. The Medicare+Choice (M+C) program, established by the Balanced Budget Act of 1997[3] (BBA), was designed to expand beneficiaries' health plan choices by encouraging the wider availability of HMOs and permitting Medicare to contract with organizations offering other types of health plans, such as preferred provider organization (PPO) plans and private fee-for-service (PFFS) plans.

In practice, however, virtually all M+C health plans in 2002 are offered by HMOs and the number of health plan choices has decreased in each of the last 4 years.[4] From 1998 to 2002, the number of Medicare contracts with HMOs declined from about 340 to 147, and the percentage of beneficiaries with access to at least one HMO in the area where they lived declined from 74 to 61 percent.[5] Enrollment in Medicare HMOs, which had reached 6.3

[1]Under a risk-based contract, an HMO receives from Medicare a fixed monthly amount per enrollee and is at financial risk for the cost of providing covered services. Some Medicare HMOs are paid under different financial arrangements.

[2]Figures for HMOs throughout this report exclude organizations that receive payments based on their costs or operate under a Medicare demonstration program.

[3]Pub. L. No. 105-33, §4001, 111 Stat. 251, 275.

[4]As of July 2002, approximately 23,000 beneficiaries were enrolled in two PFFS plans. Unlike HMOs, these plans do not restrict beneficiary choice of provider.

[5]Approximately 75 percent of beneficiaries have access to a Medicare HMO or PFFS plan in 2002.

million in 1999, had fallen to less than 5 million (12 percent of all Medicare beneficiaries) as of July 2002.

Representatives of the managed care industry have stated that declining HMO participation in Medicare is largely due to inadequate M+C payment rates and excessive administrative requirements. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999[6] (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000[7] (BIPA) increased payment rates and made other changes to help address the industry's concerns. But these legislative changes have not halted the decline in HMO participation.[8] To encourage health plans to participate in M+C, legislative proposals have been made to further increase M+C payment rates and streamline the program's administrative requirements.

To assist in your consideration of potential M+C reforms, you asked us to summarize the program's HMO requirements in four areas: (1) the annual benefit package proposals that HMOs submit, (2) the beneficiary enrollment process, (3) marketing materials and enrollee communications, and (4) quality improvement.[9] To provide benchmarks that could be used when examining M+C requirements, you asked us to summarize parallel requirements for HMOs that participate in the Federal Employees Health Benefits Program (FEHBP), another large purchaser of health care. You also asked us to describe the HMO requirements established by other entities in one or more of the four M+C areas we reviewed. In consultation with your office, we selected three entities that are not health care purchasers but that do set requirements for HMOs: the National Association of Insurance Commissioners (NAIC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National

[6]Pub. L. No. 106-113, Appendix F, Title V, 113 Stat. 1501A-321, 1501A-378-394.

[7]Pub. L. No. 106-554, Appendix F, Title VI, 114 Stat. 2763A-463, 2763A-554-569.

[8]U.S. General Accounting Office, *Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001*, GAO-02-202 (Washington, D.C.: Nov. 21, 2001).

[9]M+C requirements may be different for other types of M+C arrangements, such as PFFS or PPO plans.

Committee for Quality Assurance (NCQA).[10] NAIC, a nonprofit organization for state regulators, drafts and publishes model acts and regulations that set standards for insurers that any state may adopt in whole or in part.[11] JCAHO and NCQA, both nongovernmental and nonprofit organizations, operate nationally recognized accreditation programs for HMOs.[12]

To conduct our work, we summarized the applicable M+C requirements in federal statutes and regulations, M+C operational guidance to HMOs, and other materials prepared by the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare.[13] We obtained additional information from CMS officials. We gathered and summarized FEHBP requirements in federal statutes and regulations and FEHBP operational guidance to HMOs, various NAIC model requirements, and relevant standards from the current JCAHO and NCQA accreditation manuals.[14] We also interviewed officials from the Office of Personnel Management (OPM), the agency that administers FEHBP, and representatives of NAIC, JCAHO, and NCQA. Because M+C requirements are broadly similar to the requirements set by other entities, but may be different in specific details, we compiled our work into summary tables that provide information on the key details of each entity's requirements (see appendixes I through IV). Our work was

[10]The entities vary from one another in the term each one uses to refer to an HMO. For consistency, we use "HMO" throughout the report to mean an organization that generally requires its enrollees to receive care from a network of providers and is paid a fixed monthly amount per enrollee to provide all services. We use the term "health plan" to refer to a package of benefits an HMO offers in a specific geographic area.

[11]In this report, the provisions in NAIC model acts and regulations are referred to as model requirements.

[12]Although their HMO standards are not discussed in this report, other organizations, such as the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) or URAC/American Accreditation HealthCare Commission, offer national accreditation programs for HMOs.

[13]CMS was previously named the Health Care Financing Administration (HCFA). We use the term HCFA to refer to the agency prior to its renaming as of July 1, 2001, and CMS for references to the agency after that date.

[14]JCAHO's standards for HMO accreditation are effective January 1, 2001, through December 31, 2002. NCQA's standards for HMO accreditation are effective July 1, 2001, through June 30, 2003.

performed from June 2001 through September 2002 in accordance with generally accepted government auditing standards.

Results in Brief

M+C has HMO requirements pertaining to benefit package proposals, the beneficiary enrollment process, marketing and enrollee communication materials, and quality improvement, among other areas. An HMO must annually submit a benefit package proposal to CMS for each M+C health plan that the HMO intends to offer.[15] In its proposal, the HMO must include its projected Medicare revenues, detailed cost estimates by service category, and other information to demonstrate compliance with M+C requirements, such as those that limit a health plan's cost-sharing requirements for Medicare-covered services. M+C requirements for the beneficiary enrollment process specify the information that an HMO must include in its enrollment application and the checks that it must perform to ensure that beneficiaries who submit applications are eligible to enroll in the HMO's health plan. M+C marketing requirements prohibit HMOs from using inaccurate or misleading language in advertisements or materials distributed to enrollees. To ensure that advertisements and enrollee materials comply with M+C requirements, HMOs must submit advance copies to CMS for review and approval. M+C requirements for quality improvement specify that HMOs must undertake multiyear projects intended to improve the quality of health care and must routinely gather and report performance data to CMS.

FEHBP, another large purchaser of health care, has requirements for HMOs in all four areas we examined. For example, FEHBP requires HMOs to annually submit benefit package proposals to OPM for review. An HMO must include information to show that its proposed FEHBP premium is no higher than the premium it would charge to similarly sized commercial customers for the same package of benefits. FEHBP has relatively few requirements for HMOs regarding the beneficiary enrollment process because most of this function is performed by OPM or delegated to other federal agencies. FEHBP's marketing requirements specify that HMOs must produce comprehensive annual benefit brochures and obtain OPM approval before distributing the brochures to potential enrollees. Finally, FEHBP has set certain quality standards and requires HMOs to submit performance data to OPM.

[15] An HMO may offer multiple health plans to Medicare beneficiaries. For each health plan, the HMO must specify the benefits offered and the geographic area served.

Although NAIC, JCAHO, and NCQA do not purchase health care, each has established HMO requirements in two of the four areas we reviewed: 1) marketing and enrollee communication materials and 2) quality improvement. All three entities require HMOs to produce complete information, although JCAHO's standards do not apply to marketing materials given to prospective members. The three entities also require HMOs to design, implement, and evaluate quality improvement projects. NAIC's model requirements pertain to all HMOs in states that set HMO licensing and operating standards based on NAIC's recommendations. JCAHO's and NCQA's standards represent requirements that must be met by all HMOs that want to be accredited by JCAHO or NCQA. The requirements established by NAIC, JCAHO, and NCQA are not specifically focused on HMOs that serve Medicare beneficiaries.

In commenting on a draft of this report, CMS stated that it generally agreed with our observations. We also provided a draft of the report to OPM, NAIC, JCAHO, and NCQA and incorporated the technical comments we received from those organizations and from CMS as appropriate.

Background

M+C and FEHBP both represent large health care purchasing programs that contract with HMOs and other types of health care organizations to provide services. NAIC, JCAHO, and NCQA are not purchasers of health care, but they play important roles in establishing certain HMO requirements.

M+C

M+C is a component of Medicare, the federal entitlement program for adults age 65 and older and some individuals who are disabled or have end-stage renal disease (ESRD).[16] Medicare beneficiaries can choose to receive covered services through the FFS program or through an M+C health plan if one is offered in the area where they live.[17] HMOs and other types of

[16]Approximately 85 percent of Medicare's 40 million beneficiaries are over age 65; the remaining 15 percent are under age 65 and disabled or have ESRD.

[17]In general, beneficiaries who have ESRD may not enroll in an M+C HMO. However, beneficiaries who develop ESRD while enrolled in an M+C HMO may continue their enrollment in that M+C HMO.

health care organizations contract with CMS to offer M+C health plans.[18] HMOs participating in M+C receive fixed monthly payments for enrolled beneficiaries, regardless of what their enrollees' care actually costs, in return for providing all Medicare-covered benefits, except hospice care, and complying with all M+C requirements. CMS monitors each HMO and periodically conducts an on-site review to determine whether the HMO is complying with program requirements. The agency also requires HMOs to regularly submit certain information, such as enrollment and other data used to compute HMO payments.

In creating M+C, BBA included many requirements from the previous risk-contract program. For example, the M+C requirement that HMOs submit marketing and enrollee communications for agency approval was a requirement of the risk-contract program. BBA also included requirements that were modifications of previous ones and others that were new. For example, BBA included quality assurance requirements—such as those pertaining to the collection, analysis, and reporting of health outcomes and member satisfaction—that were more comprehensive than previous requirements. BBA required that M+C payments to an HMO be adjusted to reflect the relative health status of that HMO's enrollees beginning in 2000. The law directed the Secretary of HHS to require HMOs to submit data on their enrollees' use of inpatient hospital services and data on other services as the Secretary deemed necessary. In addition to the inpatient hospital data requirement, the Secretary required HMOs, in 1998, to collect data on the use of physician and hospital outpatient services. BBA also limited, effective January 1, 2002, the number of opportunities beneficiaries had each year to enroll or change enrollment in a M+C health plan.

M+C's requirements have continued to evolve since BBA, partly as a result of subsequent legislation. Some legislative changes addressed HMOs' concerns about BBA's initial implementation. For example, BBRA increased the amount of time that HMOs have each year to develop their benefit package proposals by moving the annual submission deadline from May 1 to July 1. To reduce the administrative burden on HMOs that are monitored by both a private accreditation organization and the agency, BBRA increased the number of topical areas where HMOs may fulfill M+C requirements by receiving accreditation from an organization that has

[18]Some beneficiaries currently have access to HMOs reimbursed on a cost basis. This arrangement is not part of the M+C program and is scheduled to end after 2004.

standards, as well as a process for ensuring compliance with those standards, which are determined by CMS to meet or exceed M+C requirements. BBA allowed accreditation standards to be applied for quality assurance and confidentiality of records requirements. BBRA expanded this list to include antidiscrimination, access to services, advance directives,[19] and provider participation requirements. Under BIPA, CMS must expedite review of HMO marketing materials that use agency-specified language without modification. BIPA also required HMOs to expand their quality improvement activities to include a separate focus on racial and ethnic minorities. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002[20] (Bioterrorism Act) made temporary modifications to M+C requirements. It enabled Medicare to reinstate, through 2004, beneficiaries' opportunities to change enrollment into any M+C health plan accepting new enrollments or switch to the FFS program on a monthly basis. It also moved the annual submission deadline for HMOs' benefit package proposals to the second Monday in September for benefit years 2003 through 2005.

CMS has also modified certain M+C requirements, in some instances to reduce the administrative burden on participating HMOs. In 2001, for example, the agency postponed the date by which HMOs would have to begin submitting data on beneficiaries' use of physician and hospital outpatient services. In 2002, CMS gave HMOs more flexibility in advertising plan benefits not available in the FFS program. For example, HMOs were allowed to describe their health plans' pharmacy discounts in the standard summary of benefits distributed to beneficiaries. CMS has also made changes to address shortcomings that agency staff or outside groups identified. The process for reviewing and approving HMOs' marketing materials was revised, in part, to correct problems we identified in 1999.[21]

Since BBA was enacted, CMS has issued *Federal Register* notices and other written instructions to inform HMOs about program changes. During 2001,

[19]An advance directive documents a beneficiary's health care preferences and instructs providers if the beneficiary cannot otherwise communicate.

[20]Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Bioterrorism Act), Pub. L. No. 107-188, §532, 116 Stat. 594, 696.

[21]U.S. General Accounting Office, *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature*, GAO/HEHS-99-92 (Washington, D.C.: Apr. 12, 1999).

CMS began releasing chapters of a new Medicare managed care manual intended to inform HMOs about program requirements.[22] As of July 11, 2002, the agency had released 9 of a planned 20 chapters.[23] No release dates have been announced for the remaining chapters.

FEHBP

FEHBP is the largest employer-sponsored group health insurance program in the United States. In 2002, FEHBP covers approximately 8.28 million individuals, consisting of 2.19 million federal employees, 1.86 million federal retirees, and 4.23 million dependents.[24] Like most Medicare beneficiaries, FEHBP beneficiaries may select from among available health plans during an annual open enrollment period. OPM contracts with HMOs and other types of health care organizations to offer health plans to FEHBP beneficiaries. The number of HMOs participating in FEHBP has declined in recent years, from 476 HMOs in 1996 to about 200 HMOs in 2002. In 2002, about 2.42 million FEHBP beneficiaries (29 percent) are enrolled in HMOs. The remaining 5.86 million beneficiaries (71 percent) are enrolled in other types of health plans, such as PPOs.

NAIC

NAIC is a nonprofit association of the insurance regulators of the 50 states, the District of Columbia, and 4 United States territories. Its mission includes promoting consistent health insurance regulations.[25] To help achieve this objective, NAIC prepares model requirements that any state may adopt, in whole or in part, to regulate HMOs operating in the state. NAIC's model requirements are largely written in general terms to provide a framework that states can tailor to meet local needs. According to NAIC,

[22]Completed chapters are available electronically through the CMS Web site. CMS intends to update released chapters quarterly.

[23]The nine released chapters cover enrollment and disenrollment, marketing, quality assurance, risk-based payments, organization compliance with state law and preemption by federal law, contracts, effect of change in ownership or leasing of facilities during term of contract, cost-based payments, and procedures for handling contract disputes.

[24]OPM enrollment estimates as of July 11, 2002.

[25]All HMOs, including those in M+C, must comply with requirements set by the states in which they operate. However, federal law specifically preempts state laws or standards pertaining to M+C in the areas of benefits (including cost sharing), inclusion and treatment of providers, coverage determinations (including grievances and appeals), and marketing materials and benefit summaries.

approximately 30 states have passed legislation based on the requirements in NAIC's Model HMO Act, which provides a legal framework for the organization and functioning of HMOs and a regulatory framework for state oversight.

JCAHO and NCQA

JCAHO and NCQA provide accreditation programs for HMOs and other health care entities that contract with public and private employers to serve their employees and retirees, with state governments to serve Medicaid beneficiaries, or with the federal government to serve Medicare beneficiaries. JCAHO's and NCQA's accreditation standards focus on the HMO operations that affect the quality of care delivered and interactions with members, rather than on all the requirements that a purchaser would typically specify for an HMO, such as the benefits offered and the cost of providing those benefits. HMOs may seek accreditation from a nationally recognized organization, such as JCAHO or NCQA, to signal their commitment to quality and to help attract business. Some potential purchasers consider an HMO's accreditation status when deciding whether to contract with the HMO.[26] An HMO's accreditation status may also be an important consideration for some potential enrollees. For that reason, OPM lists the accreditation status of participating HMOs in the annual guide made available to FEHBP beneficiaries. In addition, HMOs with M+C health plans that have received full accreditation from JCAHO or NCQA, and have been determined by one of those organizations to have met certain additional standards, are considered by CMS to have met the M+C quality requirements discussed in this report.[27]

[26]A February 2002 survey conducted by NCQA found that 153 Fortune 500 companies, 42 percent of which are Fortune 100 companies, relied on NCQA accreditation when making their health plan purchasing decisions.

[27]HMOs may also satisfy M+C quality requirements by receiving full accreditation from AAAHC and meeting certain additional standards. The accreditation standards of AAAHC, JCAHO, and NCQA do not address every M+C quality requirement specified by CMS. These organizations agreed to implement and enforce standards specifically for M+C HMOs. For instance, as part of their M+C accreditation processes, AAAHC and JCAHO agreed to require M+C HMOs to evaluate annually the effectiveness of their quality assurance and performance improvement program strategies.

Selected M+C Requirements for HMOs

An HMO that contracts to serve Medicare beneficiaries must meet M+C program requirements specified by CMS regarding benefit package proposals, the beneficiary enrollment process, marketing and enrollee communications, and quality improvement. Requirements pertaining to benefit package proposals specify the information that HMOs must annually submit to CMS and set coverage parameters, such as limits on beneficiary cost sharing. Beneficiary enrollment process requirements establish how HMOs must collect and process applications, conduct beneficiary eligibility checks, transmit information to CMS, and reconcile data discrepancies. Communication requirements, which cover both general advertising and specific communications to enrollees, set standards for the information that HMOs distribute to beneficiaries and establish CMS's review and approval process for these materials. Requirements for quality improvement specify that HMOs have the capacity to undertake projects designed to improve the quality of health care and annually measure their clinical and administrative performance and the satisfaction of current and former enrollees.

Benefit Package Proposals

For each M+C health plan that it intends to offer, an HMO must annually submit a benefit package proposal for CMS review and approval. BBRA specified that proposals are due at the beginning of July—6 months before the start of the benefit year. The Bioterrorism Act temporarily changes the benefit package proposal submission deadline to the second Monday in September for 2002 through 2004.[28] The proposals, formally known as adjusted community rate proposals (ACRP), specify the health plan's covered benefits, beneficiary cost sharing, and beneficiary premiums. An HMO must cover all services available in the FFS program except hospice. An HMO may also offer additional services, such as outpatient prescription drugs, and charge beneficiaries for these services. If Medicare's payments to an HMO are expected to exceed its cost of providing Medicare-covered services plus the amount of profit or additional revenue that the HMO would normally earn on non-Medicare contracts, the HMO must use the additional money to cover additional items or services, reduce beneficiary cost sharing, or contribute to a benefit stabilization fund—an escrow-like account that can be drawn upon in future years to help maintain benefit

[28]Bioterrorism Act, §532(b), 116 Stat. 696.

levels—or a combination of these. The HMO's benefit package proposal describes the extent to which these options will be used.[29]

CMS reviews HMOs' benefit package proposals and approves them if they comply with M+C requirements. For example, an HMO may set beneficiary cost-sharing requirements on individual services that differ from those in the FFS program, but the sum of the actuarial value of its cost-sharing requirements—the total amount that the average beneficiary would be expected to pay in deductibles, coinsurance, and copayments—and the health plan premium may not exceed the actuarial value of cost sharing in the FFS program. The agency has generally approved the proposals before the start of Medicare's annual enrollment period in November. BIPA requires the agency's Chief Actuary to review all benefit package proposals submitted on or after May 1, 2001, to determine whether the data values and underlying assumptions in the proposals are reasonable. According to CMS officials, actuary reviews will begin with benefit package proposals submitted in 2002. BBA requires CMS each year to audit the benefit package proposals from at least one-third of the participating M+C HMOs.[30] CMS uses a risk-based approach to select some of the HMOs to audit, but the majority of audited HMOs are randomly selected.

Beneficiary Enrollment Process

HMOs are required to play a major role in the beneficiary enrollment process. A beneficiary who wants to enroll in a health plan submits an application to the HMO, which then must make a preliminary determination about whether the beneficiary lives in the geographic area served by the health plan and is otherwise eligible to enroll. The HMO then forwards the beneficiary's information to CMS. After CMS confirms enrollment eligibility, the HMO must determine the date that coverage will begin and notify the beneficiary. Through December 31, 2004, beneficiaries are allowed to join or leave health plans each month. After that date, beneficiaries will have fewer opportunities each year to make health plan changes.

[29]GAO-02-202.

[30]For a review of the first year's audits, see U.S. General Accounting Office, *Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness*, GAO-02-33 (Washington, D.C.: Oct. 9, 2001).

Marketing and Enrollee Communication Materials

HMOs must provide accurate and complete information to prospective beneficiaries and current enrollees. CMS's requirements cover the advertising and marketing materials that HMOs distribute to prospective beneficiaries and the communications between HMOs and their enrollees, such as explanations of benefits or coverage denials. For some materials, such as the summary document that each HMO must produce to describe its health plan's benefits, CMS requires HMOs to use templates with standardized language and formats. Prior to distribution, HMOs must submit all of their marketing and most of their enrollee communication materials to CMS for review and approval.

Quality Improvement

HMOs must meet M+C requirements designed to improve the quality of care and services they deliver. Every year, an HMO must begin a multiyear quality improvement project that focuses on a topic specified by CMS (the national quality improvement project). For example, in 2002, CMS requires HMOs to participate in the national quality improvement project designed to improve breast cancer screening rates. An HMO must also demonstrate that its previous quality improvement projects have resulted in demonstrable performance improvements and sustain those improvements for at least 1 year.[31] HMOs must participate in annual CMS-sponsored standardized satisfaction surveys of current enrollees and recent disenrollees and provide clinical and administrative data to CMS.

Recently, CMS determined that AAAHC's, JCAHO's, and NCQA's standards, and their processes for ensuring compliance with those standards, meet or exceed M+C requirements for quality improvement. As a result, an HMO that has received full accreditation from AAAHC, JCAHO, or NCQA may now choose to have the accreditation organization, instead of CMS, monitor its compliance with M+C quality improvement requirements.

[31]Before 2002, an HMO also had to initiate a multiyear quality improvement project on a topic that the HMO selected. In 2002, CMS eliminated this requirement. An HMO must report on the improvements achieved from projects begun in 1999 and 2000, but does not have to maintain them. An HMO must report the topic and baseline data for the project it began in 2001, but does not have to maintain the project.

Selected FEHBP Requirements for HMOs

FEHBP has requirements for HMOs in all four areas we examined: benefit package proposals, the beneficiary enrollment process, marketing materials and enrollee communications, and quality improvement. Although FEHBP and Medicare both function as purchasers and are broadly similar in terms of offering a choice of plans to beneficiaries, there are key differences in how the two programs operate, which may account for some of the variation in requirements. For example, market forces determine HMO payment rates in FEHBP. In contrast, a statutory formula specifies HMO payment rates in M+C.[32] The difference in rate-setting methodologies affects the type of information that OPM and CMS require HMOs to include in their benefit package proposals. The programs also differ in size and beneficiary characteristics. FEHBP covers about one-fifth as many individuals as Medicare does. Moreover, FEHBP beneficiaries tend to be younger and to use fewer health care services than Medicare beneficiaries.

Benefit Package Proposals

HMOs that intend to participate in FEHBP must annually submit benefit package proposals to OPM for each health plan they offer. The proposals are due in May, at least 7 months before the start of the benefit year. In general, the FEHBP benefit package that an HMO offers in a geographic area provides the same coverage that the HMO offers to most enrollees in the same area. Each proposal includes the proposed health plan premium, which must be based on the lowest community-rated premium that the HMO charges to commercial customers for a similar number of covered lives.[33] OPM actuaries evaluate an HMO's supporting documentation for the proposed premium. The benefits to be covered by a health plan and its cost to the government and to enrollees may be affected by subsequent discussions between OPM and the HMO. For example, OPM may question specific cost estimates submitted by an HMO if they are much higher than other HMOs' estimates. In such a situation, according to OPM, the agency will not agree to a rate unless these higher costs are adequately justified. Negotiations are generally concluded in August, at least 2 months before the start of FEHBP's annual enrollment period in November.

[32]BBA, §4001, 111 Stat. 299.

[33]Community-rated premiums reflect the average actual or anticipated cost of all enrollees in a specific geographic area.

FEHBP HMOs are subject to audits by OPM's Office of Inspector General (OIG). If an HMO is found to have overcharged the government, the HMO must repay the amount of the overcharge plus interest. The OPM OIG has a goal of auditing every HMO at least once every 7 years. However, its audit strategy is risk based and concentrates resources on HMOs where problems are thought most likely to be found.

Beneficiary Enrollment Process

While FEHBP has some enrollment process requirements for HMOs, they are limited because OPM and agencies that employ federal workers are responsible for most enrollment activities. FEHBP HMOs' primary enrollment responsibility is to confirm that applicants live in, or in some cases work in, the geographic area served by their health plan. HMOs must also quarterly reconcile enrollments with agencies. Beneficiaries who are active workers enroll through the federal agencies that employ them, either in writing or through an automated telephone system or a dedicated Web site. The agencies determine eligibility and coverage start dates. Retirees enroll through an automated telephone system or a dedicated Web site. Agencies conduct tentative eligibility determinations for retirees that OPM then confirms. In general, FEHBP allows beneficiaries to switch health plans once a year, during the annual open season.

Marketing and Enrollee Communication Materials

FEHBP requires HMOs to produce annual brochures in a standard format using standard language. The brochure must completely describe the covered benefits, limitations, and exclusions. According to OPM officials, the brochures represent a contractual document between HMOs and OPM. OPM must approve HMOs' brochures before they can be distributed. HMOs must conform to OPM and NAIC guidelines in preparing materials that supplement the brochure and marketing materials, such as descriptive circulars and leaflets. According to OPM representatives, the agency focuses its review efforts on the annual brochures, but may selectively review other marketing materials distributed by HMOs.

Quality Improvement

HMOs must meet performance standards specified in their FEHBP contracts. These standards cover such areas as timeliness of telephone responses and wait times for appointments. FEHBP HMOs must annually conduct a standardized enrollee satisfaction survey and provide clinical and administrative performance data to OPM. FEHBP HMOs currently do not have to conduct quality improvement projects. However, in 2001,

HMOs had to submit their business plans and timelines for attaining accreditation from an approved external accreditation organization; OPM currently recognizes JCAHO, NCQA, and URAC/American Accreditation HealthCare Commission. To achieve accreditation from such an organization, HMOs have to undertake quality improvement projects.

Selected NAIC, JCAHO, and NCQA Requirements for HMOs

NAIC, JCAHO, and NCQA have established standards for HMOs in two of the areas we examined: 1) marketing and enrollee communication materials and 2) quality improvement. NAIC, JCAHO, and NCQA have not set standards for either benefit package proposals or beneficiary enrollment—two areas that health care purchasers must address. The three entities tend to establish standards that are less specific than parallel M+C requirements and that may be modified or interpreted to fit local circumstances.

Marketing and Enrollee Communication Materials

NAIC's model requirements for marketing materials specify that an HMO must produce advertising that is clear, complete, and does not mislead beneficiaries. HMOs may be required to annually certify that their marketing materials comply with a state's insurance laws and regulations or to submit their marketing materials to a state insurance commissioner prior to distribution. NAIC's model requirements for enrollee communications focus on HMO contract documents and specify that state insurance commissioners can require HMOs to file these documents for approval by the state prior to issuance. NAIC's model requirements pertain to the general contents of contract documents, but not the use of standardized formats or language.

JCAHO's and NCQA's accreditation standards require HMOs to provide complete information to their enrollees. NCQA's accreditation standards also apply to marketing materials intended for prospective members. Both organizations have general content requirements and review marketing materials during their on-site accreditation visits. NCQA requires that HMOs have a systematic and ongoing process for assessing how clearly new enrollees understand HMO policies and procedures.

Quality Improvement

NAIC's model requirements specify that HMOs must have a quality improvement program to improve care delivery and health outcomes and to collect and analyze information specific to their enrollees, such as

satisfaction with the HMO. However, NAIC does not specify the types of quality improvement projects that HMOs must conduct or require the use of standardized satisfaction surveys or standardized performance measures.

Both JCAHO's and NCQA's accreditation standards require HMOs to design and conduct quality improvement projects in clinical and administrative areas that achieve meaningful, sustainable performance improvements affecting a significant percentage of their enrollees. JCAHO and NCQA evaluate quality improvement project results during their accreditation site visits. Both organizations also require HMOs to measure enrollee satisfaction and submit administrative and clinical performance data.

Comments from CMS and the Other Entities

In written comments on a draft of this report, CMS stated that it generally agreed with our observations and that the tables contained in the appendixes effectively contrast M+C's, FEHBP's, and the other entities' HMO requirements. (App. V contains the full text of CMS's comments.) CMS suggested that an expanded analysis of the differences between M+C and FEHBP programs, and a more detailed discussion of M+C's legislative history, could help readers understand why M+C's HMO requirements may be more stringent.

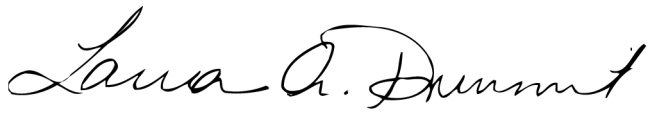
We recognize that there are fundamental differences between Medicare—a large public entitlement program—and FEHBP—an employer-sponsored health insurance program—and that an HMO requirement that is appropriate in one program may not be appropriate in the other. In this report, we provide background information on M+C, FEHBP, and the other entities to help provide context for their HMO requirements. We also understand that behind M+C's current set of requirements lies a complex legislative history and a series of administrative decisions. The report highlights important Medicare HMO requirement changes introduced by BBA and subsequent actions taken by CMS and the Congress to improve M+C for beneficiaries and encourage participation by HMOs. However, the report's focus is on the requirements that M+C HMOs face today. By displaying these requirements with the HMO requirements established by other entities, the summary tables may facilitate comparisons and inform discussions about particular M+C requirements and how they contribute to the program's objectives.

We also provided a draft of the report to OPM, NAIC, JCAHO, and NCQA and incorporated the technical comments we received from those organizations and from CMS as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this report. We will then send copies of this report to the Administrator of CMS, the Director of OPM, NAIC, JCAHO, NCQA, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have questions about this report, please contact me at (202) 512-7119 or James Cosgrove at (202) 512-7029. Other contributors to this report include Jennifer Podulka, Lisa Rogers, and Yorick F. Uzes.

Sincerely yours,



Laura A. Dummit
Director, Health Care—Medicare Payment Issues

Benefit Package Proposals

M+C and FEHBP have HMO requirements that pertain to benefit package proposals. Our summary of those requirements is organized as follows.

Determination of Costs, Benefits, and Government and Beneficiary Contributions

- Purpose of benefit package proposals
- Determination of HMO costs or rates
- Covered benefits
- Government contribution
- Beneficiary contribution
- Limits on premiums and required cost sharing

Submission, Review, and Approval of Benefit Package Proposals

- Call for proposals
- Number of proposals submitted
- Contents of proposals
- Transmission of proposals
- Proposal submission deadline
- Deadline for informing CMS/OPM that existing health plan will not renew
- Review process
- Schedule for approving proposals
- Reconciliation process

Benefit Package Proposal Audits

- Entities that conduct audits

- Selection criteria for audits and number of HMOs audited annually
- Information subject to audit
- Timing of audits
- Contents of audit reports
- Consequences of audit findings

Table 1 summarizes selected M+C and FEHBP requirements for HMOs' benefit package proposals. Figure 1 depicts the 2001 benefit-year timeline for activities associated with the submission, review, and approval of HMOs' benefit packages.[34] The timing of these activities for M+C will be altered for benefit years 2003 through 2005. Figure 2 depicts the M+C and FEHBP timeline for benefit package proposal activities for those benefit years.

[34]For benefit year 2002, CMS allowed M+C HMOs to submit benefit package proposals as late as September 17, 2001, and extended the annual enrollment period through December 31, 2001.

Table 1: Selected Requirements for Benefit Package Proposals, M+C and FEHBP

Topic	M+C requirements	FEHBP requirements
Determination of costs, benefits, and government and beneficiary contribution		
Purpose of benefit package proposals	HMO must submit, for CMS approval, benefit package proposals, called adjusted community rate proposals (ACRP), that are used to determine covered benefits and beneficiary premiums and cost sharing.	HMO must submit, for OPM approval, benefit package proposals that are used to determine covered benefits, the government contribution, and beneficiary premiums and cost sharing.
Determination of HMO costs or rates	HMO must, for each health plan it intends to offer, estimate its per enrollee direct medical cost of providing Medicare-covered benefits. The HMO must also list the payments per enrollee it requires to cover administrative costs and provide other additional revenue, for such items as profits or contribution to reserve for nonprofit HMOs. (The profit included in the proposal must be comparable to the profits the HMO normally earns on other contracts.) The HMO must follow the same methodology to estimate its cost and revenue of providing benefits not covered by Medicare. The sum of all direct medical and administrative costs and additional revenue per enrollee, known as the adjusted community rate (ACR), must be based on the amount the HMO would charge a commercial or other customer to provide benefits, adjusted for differences in the utilization characteristics of the HMO's expected Medicare enrollees.	HMO must, for each health plan it intends to offer, develop its FEHBP premium rates using the same methodology it uses for other purchasers. Each HMO must identify two purchasers in the FEHBP contract area with enrollments closest to the number of its FEHBP enrollees in that area. These purchasers are referred to as similarly sized subscriber groups (SSSG). The HMO must apply the same methodologies it used to calculate premium rates for its SSSGs and select the method that yields the lowest premium rate for FEHBP. The premium rate may be adjusted to incorporate findings from rate reconciliation audits.
Covered benefits	HMO must provide all Medicare-covered benefits except hospice care. HMO may enhance Medicare's benefit package by reducing beneficiary cost-sharing requirements or providing coverage for additional benefits, such as prescription drugs. If projected Medicare payments exceed the HMO's ACR, the HMO must use the excess by enhancing benefits or contributing to a benefit stabilization fund that it can draw on in future years to help finance the cost of covered benefits, or a combination of these. Beginning in 2003, HMO may pay all or part of a beneficiary's Medicare part B premium.[a]	In general, an HMO's FEHBP benefit package is expected to be based on the benefit package it provides to the most enrollees in the community. OPM may require HMOs to provide coverage for certain benefits, such as prescription drugs or child immunizations, or may establish coverage parameters, such as minimum copayments or parity for mental health benefits. OPM may restrict benefits, such as dental coverage, that might result in an HMO attracting a disproportionate number of healthy beneficiaries, a phenomenon known as favorable selection.

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Topic	M+C requirements	FEHBP requirements
Government contribution	CMS follows a formula specified in law to establish the government contribution to an M+C HMO in each geographic payment area (generally a county).[b]	OPM follows a formula specified in law to establish the government premium contribution.[c] For each enrollee, the government pays the HMO the lesser of: 1. 72 percent of the weighted average premium of all health plans offered to government employees (average premium weighted by the number of FEHBP enrollees in each health plan), or 2. 75 percent of the health plan's premium.
	M+C payment rates are adjusted, up or down, to better reflect the likely health care costs associated with certain beneficiary characteristics such as age, sex, Medicaid enrollment status, and prior hospitalizations for selected conditions.	OPM does not adjust payments for the characteristics of individual enrollees.
Beneficiary contribution	Beneficiary premium is established in conjunction with the health plan's cost-sharing requirements. In general, beneficiaries are expected to pay, in premiums and cost sharing, the difference between the health plan's ACR for its entire benefit package and the portion of Medicare's payment used by the health plan for current benefits.[d]	Beneficiary pays the difference between health plan's premium and the government contribution per enrollee. Beneficiary must pay a minimum of 25 percent of the health plan's premium. In addition, beneficiary must pay any required cost sharing.
Limits on premiums and required cost sharing	No minimum premiums or required cost sharing. For Medicare-covered benefits as a whole, the expected premiums and cost sharing per beneficiary cannot exceed a nationally established amount representing the actuarial value of FFS's deductibles and coinsurance. CMS may limit cost sharing for individual items and services if it determines that the health plan's proposed cost sharing would, for example, discriminate or discourage enrollment of severely ill or chronically ill beneficiaries. For benefits not covered by Medicare, the expected revenue per beneficiary cannot exceed the health plan's ACR for the group of benefits.	No maximum premiums or required cost sharing. OPM sets some minimum copayment amounts.
Submission, review, and approval of benefit package proposals		
Call for proposals	No later than March 1 of each year, which has been temporarily changed to no later than the second Monday in May in 2004 and 2005, CMS announces the M+C payment rates for each geographic payment area that will be in effect during the next calendar year.[e] (M+C benefit year coincides with the calendar year.)	In March or early April, OPM sends out a "call letter" asking HMOs to submit their benefit package proposals for the next benefit year. The call letter contains information on any program changes that could affect an HMO's rates.
Number of proposals submitted	CMS received about 650 ACRPs in 2001.[f]	OPM received about 300 benefit package proposals in 2001.

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Topic	M+C requirements	FEHBP requirements
Contents of proposals	An HMO must submit an ACRP for each heath plan it intends to offer. The ACRP consists of two parts—(1) a set of six standardized spreadsheets that support the health plan's ACR and (2) a standardized list, known as the plan benefit package (PBP), that details all the benefits the HMO will offer. The six ACR spreadsheets ask for the following information. • Summary projections of enrollment, Medicare's average payment rate, and revenue collected from beneficiaries. • Base-year actual costs and revenues. (HMO uses recent historical costs and revenues as a basis to project benefit-year costs and revenues. The base year is the period when historical costs and revenues are measured. Base-year costs are adjusted for expected trends and other factors to project benefit-year costs and revenues.) • HMO financial information. • Premiums and cost-sharing details for various categories of services. • Expected variation in costs and revenues by health care service category. • Calculation comparing the ACR to Medicare's projected average payment rate.	An HMO must submit, for each health plan it intends to offer, information that describes how it developed rates for its SSSGs and shows that it used the same methodology to develop its FEHBP rates. HMO submits OPM-required forms and supporting documentation for each of its health plans. OPM forms primarily consist of a series of questions. Many questions have multiple-choice answers; others ask for a narrative description of the HMO's rate development methodology. The supporting documentation can be submitted in any form that is convenient for the HMO and supplies the necessary information. The number of forms and amount of documentation required vary according to whether the health plan serves more or less than 1,500 FEHBP enrollees and whether total income from FEHBP is less than or more than $500,000.[g]
Transmission of proposals	HMO submits ACRPs electronically and mails a paper copy of the ACR to CMS along with narrative descriptions that may contain additional explanations or cost justifications.	HMO mails two paper copies of benefit package proposals or other required documentation to OPM.
Proposal submission deadline	July 1 before the start of the benefit year. For benefit years 2003 through 2005 only, the deadline is the second Monday in September.[h]	May 31 before the start of the benefit year.
Deadline for informing CMS/OPM that existing health plan will not be renewed	July 1 before the start of the benefit year. For benefit years 2003 through 2005 only, the deadline is the second Monday in September.	May 31 before the start of the benefit year. If OPM does not receive a benefit package proposal for an existing health plan by that date, the agency regards the health plan as one that will not be renewed.

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Topic	M+C requirements	FEHBP requirements
Review process	CMS electronically reviews each ACRP, primarily to check that all required fields are completed. CMS and CMS's contractors conduct a desk review of the ACRP. The desk review includes verifying that any projected Medicare average payment rate in excess of the HMO's ACR is used to offer additional benefits, to reduce premiums or cost sharing, or is placed in the stabilization fund; that benefits detailed in the PBP are included in the ACR; and that all values in the ACR appear reasonable and are supported by adequate documentation.	OPM uses a two-stage process to review HMOs' benefit package proposals and begin negotiations. First, OPM's Office of Insurance Programs reviews each proposed benefit package. OPM may negotiate to have the HMO alter its proposed benefit package. Second, OPM's Office of the Actuary reviews the proposed premium rate and the data and methodology the HMO used to develop the rate. (These two stages do not necessarily occur in strict sequence and OPM may continue benefit negotiations while reviewing the HMO's premium rates.)
	BIPA requires Medicare's Chief Actuary to review all ACRs submitted on or after May 1, 2001, and determine the appropriateness of both the actuarial assumptions and the data used by HMOs.[i] CMS officials have stated that actuarial reviews will begin with ACRs submitted in 2002.	OPM's Office of the Actuary focuses review efforts on benefit package proposals that cover more than 1,500 FEHBP enrollees. For benefit package proposals covering 1,500 or more FEHBP enrollees, OPM checks that the HMO used the same methodology for its SSSG as for FEHBP. About 160 benefit package proposals were subject to this detailed review in 2001. For benefit package proposals covering fewer than 1,500 FEHBP enrollees, OPM determines whether the proposed rates appear to be reasonable (for example, by comparing the rates with those submitted by similar HMOs).
Schedule for approving proposals	CMS generally completes its review of ACRPs and approves them before the start of Medicare's annual enrollment period in November.[j]	OPM tries to finish all negotiations by mid-August—approximately 10 weeks before the start of FEHBP's open season that begins in November.
Reconciliation process	No applicable requirements.	In early March of the benefit year, each HMO must tell OPM what rate it actually negotiated with its SSSGs. (The HMO may have signed contracts with its SSSGs after submitting its FEHBP rate proposal.) If the lowest SSSG rate differs from the one listed in the HMO's FEHBP rate proposal, OPM reconciles the difference and determines whether the HMO undercharged or overcharged FEHBP. The reconciliation process is also used to make adjustments for FEHB program changes announced after benefit package proposals were finalized and approved. An HMO cannot use the reconciliation process to update its estimates of beneficiary use of services. OPM maintains a contingency reserve fund for HMOs, and may charge an HMO up to 3 percent of its health plan's premium to establish and maintain the fund.

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Topic	M+C requirements	FEHBP requirements
		Funds are paid out of the health plan's contingency reserve to: compensate a health plan if its rate at the time of reconciliation (late spring, early summer) is higher than that agreed to in rate negotiations; reduce the rate otherwise applicable for a year if the contingency reserve is projected to exceed the minimum balance; and reimburse the Federal Employees Health Benefits Fund for audit findings against a health plan.
Benefit package proposal audits		
Entities that conduct audits	For audits of benefit year 2000 ACRPs, CMS contracted with three private certified public accounting firms and HHS's Office of Inspector General (OIG). For audits of benefit year 2001 ACRPs, CMS contracted with only private firms.	OPM OIG.
Information subject to audit	BBA grants the Secretary of HHS the right to audit and inspect any books and records of the HMO that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract. Audits analyze each of the six ACR worksheets, but primarily focus on two aspects of the ACR–the actual costs incurred in the base year, and the methodology the HMO used to project benefit-year costs from base-year costs.	OPM OIG conducts two types of audits: rate reconciliation audits of benefit package proposals for the current benefit year, and historical audits that generally review benefit package proposals from 5 previous benefit years. Audits determine whether the HMO's rate was developed according to the contract, the Federal Acquisition Regulation (FAR), which contains generic procurement rules contractors follow in doing business with the federal government, and the Federal Employees Health Benefits Acquisition Regulation, which tailors FAR to FEHBP.
Selection criteria for audits and number of HMOs audited annually	CMS is required to audit at least one-third of the participating HMOs annually.[k] CMS selected every third HMO contract from those filing ACRPs for 2000. CMS then used a risk-based approach to eliminate or add HMO contracts based on the desk reviews and prior experience with particular HMO contracts. CMS audited 80 of the 238 M+C contracts for the 2000 benefit year. CMS's goal is to audit all M+C contracts over a 3-year period.	The FEHB Act permits, but does not require, audits of HMOs. OPM OIG performs a risk analysis by assigning all of an HMO's health plans a numerical value for criteria such as nature of previous findings, size of health plan, dollar volume, and time elapsed since last audit. Aggregate score for each HMO is computed, and HMOs with the highest risk scores are audited. In 2001, OPM OIG performed 20 rate reconciliation audits and 23 historical audits of HMOs. OPM tries to audit each HMO at least once every 7 years.
Timing of audits	Audits of ACRPs for benefit year 2000 were conducted from May through November 2000. (HMOs had originally submitted these ACRPs in July 1999.)	Rate reconciliation audits of benefit package proposals are conducted from May through August of the benefit year covered by the proposal. Historical audits are conducted from August through May.

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Topic	M+C requirements	FEHBP requirements
Contents of audit reports	CMS's contract for benefit year 2000 required that the audit reports contain a discussion of each audit finding, a revised ACRP showing the estimated dollar effect of each audit finding, and a conclusion about the reasonableness of the audited ACRP.	Audit reports contain a discussion of each audit finding and the dollar effect of each audit finding.
Consequences of audit findings	Depending on the audit findings accepted by CMS, an HMO could be subject to administrative sanctions, civil money penalties, and be required to return double the excess amount charged in violation. The excess amount charged is deducted from the penalty and returned to the Medicare enrollee(s) concerned. CMS has provided copies of the 2000 benefit-year audit reports to HMOs. The agency is considering the actions it will take to address the audit findings.	If OPM OIG determines that rates equivalent to the SSSGs' rates were not applied to the FEHBP, it can return a finding of defective pricing. FEHBP is then entitled to a downward rate adjustment to compensate for any overcharges and interest on overcharges.

[a]Part A of Medicare provides coverage for inpatient hospital, skilled nursing facility, hospice, and certain home health care services, for which beneficiaries do not pay a premium. To receive coverage for physician and other services provided under part B of Medicare, beneficiaries must pay a monthly premium to Medicare. In general, a beneficiary enrolled in an M+C health plan must pay Medicare's part B premium in addition to any premium charged by the health plan.

[b]Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, §4001, 111 Stat. 251, 299 (classified to 42 U.S.C. 1395w-23).

[c]5 U.S.C, §8906.

[d]Under certain circumstances, an HMO may contribute a portion of its Medicare payment to a benefit stabilization fund to finance benefits in future years, or draw on its previous contributions to finance current benefits.

[e]Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Bioterrorism Act), Pub. L. No. 107-188, §532(d), 116 Stat. 594, 696.

[f]This reflects the number of revised ACRPs filed following the enactment of BIPA, which required HMOs to submit revised ACRPs to cover the portion of the 2001 contract year—March through December—when BIPA specified increased payment rates would be in effect.

[g]OPM measures enrollment for this purpose in terms of numbers of contracts between an FEHBP health plan and federal employees, retirees, or surviving dependents. Thus, the number of contracts is less than the number of covered lives, which includes covered spouses and dependent children.

[h]Bioterrorism Act, §532(b), 116 Stat. 696.

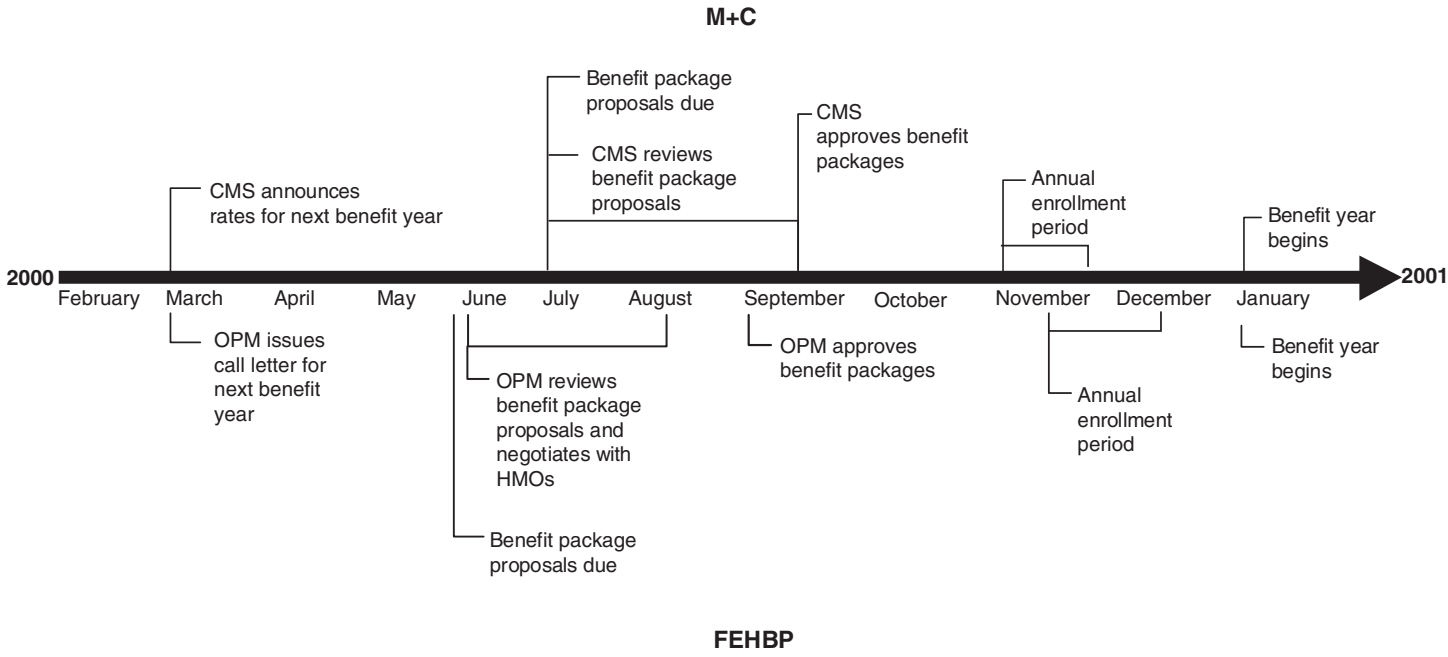
[i]Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, Appendix, F, §622, 114 Stat. 2763A-463, 2763A-566.

[j]The Bioterrorism Act temporarily changes the date of the annual enrollment period that occurs before the start of each benefit year (§532(c), 116 Stat. 696). BBA specified the month of November as the annual enrollment period (BBA, §4001, 111 Stat. 282). For benefit years 2003 through 2005, the Bioterrorism Act delays the start of the annual enrollment period to November 15 and extends its conclusion to December 31 during the years 2002 through 2004 (§532(c), 116 Stat. 696). For the 2003 benefit year, CMS intends to complete its review of submitted ACRPs by November 1, 2002, approximately 2 weeks prior to the start of Medicare's open enrollment period.

[k]BBA, §4001, 111 Stat. 320. Audits were first conducted for benefit year 2000 ACRPs.

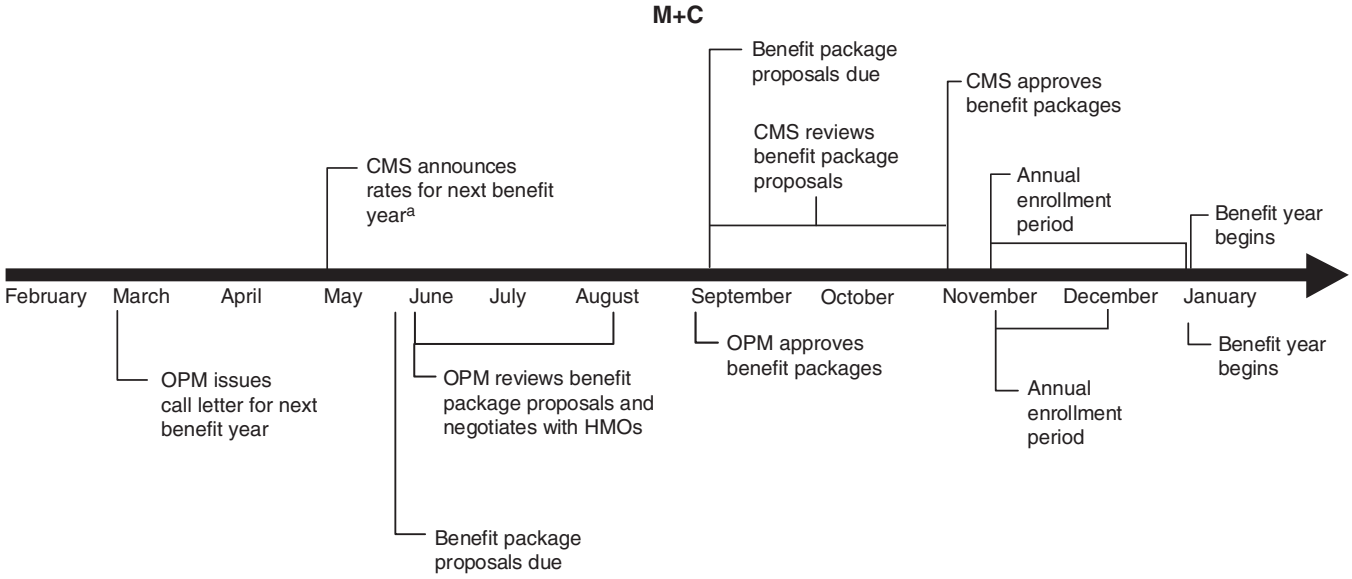
Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes, operational guidance, and other agency materials pertaining to HMOs, and interviews with officials.

Figure 1: Timeline for Submission, Review, and Approval of HMOs' Benefit Package Proposals for Benefit Year 2001



Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials.

Figure 2: Timeline for Submission, Review, and Approval of HMOs' Benefit Package Proposals for Benefit Years 2003 Through 2005



Note: For benefit years after 2005, schedule of M+C activities will revert to the schedule shown in fig. 1.

[a]CMS announced payment rates for benefit year 2003 in March 2002.

Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials.

Beneficiary Enrollment

M+C and FEHBP have HMO requirements that pertain to beneficiary enrollment. Our summary of those requirements is organized as follows.

Enrollment Process

- Enrollment application
- Eligibility determination
- Transmission of enrollment information to HMOs
- Reconciliation of data between HMO and administering agency

Timing of Enrollment Changes

- Opportunities to enroll or change enrollment
- Requirements for health plans to accept new enrollees
- Determination of effective coverage dates

Enrollment and Disenrollment Forms and Notices

- Enrollment forms
- Notifications for other enrollment-related situations
- Forms and notifications for voluntary disenrollment
- Notifications for other disenrollment-related situations

Table 2 summarizes selected M+C and FEHBP requirements pertaining to beneficiary enrollment. Table 3 summarizes the annual opportunities for Medicare beneficiaries to enroll in an M+C health plan, change M+C health plans, or switch to FFS under M+C's enrollment "lock-in" provision. This provision was in effect during the first half of 2002 and will be implemented again as of January 1, 2005. Until that date, Medicare beneficiaries may make enrollment changes every month. Table 4 summarizes the annual opportunities for FEHBP beneficiaries to make health plan enrollment changes.

Table 2: Selected Requirements for Beneficiary Enrollment in HMOs, M+C and FEHBP

Topic	M+C requirements	FEHBP requirements
Enrollment process		
Enrollment application	Medicare beneficiaries apply in writing to HMO. HMO must accept mailed and faxed enrollment forms and those presented in person.	Employees: During open season, agencies may permit or require their employees to submit applications to OPM via an automated telephone system or Web site. Employees who do not use the automated systems apply in writing to their agency's human resources office. Retirees: During open season, retirees may change enrollment via an automated telephone system or Web site provided by OPM. Outside of open season activities, retirees make enrollment changes by using a toll-free telephone number provided by OPM.
Eligibility determination	HMO must verify completion of enrollment forms and perform initial checks to verify eligibility for M+C. Eligibility determination requires, but is not limited to, verification of enrollment in Medicare parts A and B and residence in the health plan's service area. HMO may access CMS data to verify enrollment in Medicare parts A and B. HMO must electronically submit new enrollments to CMS monthly. CMS performs final eligibility checks. HMO can electronically review the results of CMS reports to confirm eligibility for new enrollees.[a]	HMO plays a limited role in the eligibility determination process. Agencies must determine eligibility for employees. For retirees, agencies must conduct initial determinations, then submit the results of those determinations to OPM for confirmation. HMO's responsibility is to confirm that applicants are eligible for its particular health plan or health plans. For example, if an HMO offers a health plan only in a designated service area, it must confirm that applicants reside in that service area.
Transmission of enrollment information to HMOs	HMO receives enrollment forms directly from beneficiary.	Employees: Excluding open season activities, agencies send copies of the enrollment forms directly to HMO. The copies must be forwarded at least every week. Several agencies send changes indirectly through OPM's enrollment processing center in Macon, Georgia. During open season, OPM sends enrollments received electronically to HMO via its enrollment processing center. These transactions occur weekly. Retirees: HMO receives non-open season enrollment changes directly from OPM. During open season, enrollment changes are made via an automated telephone system or a Web site provided by OPM. OPM sends these changes to the HMO electronically through its enrollment processing center.

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Topic	M+C requirements	FEHBP requirements
Reconciliation of data between HMO and administering agency	Enrollment data are electronically reconciled between HMO and CMS monthly. HMO can electronically view reports with results of CMS eligibility confirmation.	Enrollment data are reconciled in writing between the HMO and agency personnel and payroll offices quarterly.
Timing of enrollment changes		
Opportunities to enroll or change enrollment	During the first 6 months of 2002, Medicare beneficiaries were subject to a lock-in provision that limited the number of opportunities they had each year to enroll or change enrollment in M+C health plans. HMOs were required to track a beneficiary's enrollment changes to ensure compliance with those limits. On June 12, 2002, the lock-in requirement was temporarily dropped until January 1, 2005. Through December 31, 2004, Medicare beneficiaries can enroll, on a monthly basis, into any M+C health plan accepting new enrollments or switch to the FFS program. (See table 3 for beneficiaries' opportunities to make health plan changes under the lock-in provision.)	OPM requirements delineate specific opportunities to enroll or change enrollment in FEHBP health plans. FEHBP eligibles enroll in their first health plan and are then locked into that health plan until the annual open season, unless special circumstances arise. Employees and retirees enrolled in FEHBP generally may only change health plans during the annual open season. FEHBP enrollees in certain circumstances have other opportunities to change enrollment. For example, they may change health plans if their employment status or family status changes. (See table 4 for specific FEHBP enrollment opportunities.)
Requirements for health plans to accept new enrollees	In general, unless an HMO's health plan has reached its CMS-approved capacity limit, it must accept beneficiaries who apply. HMO may not screen beneficiaries prior to enrollment. HMO may not reject beneficiaries who have preexisting conditions, other than end-stage renal disease.	HMO must accept all eligible applicants. HMO may not reject applications due to preexisting conditions.

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Topic	M+C requirements	FEHBP requirements
Determination of effective coverage dates	HMO must determine effective coverage dates based on the election period.	Agency personnel offices must determine effective coverage dates based on the election period.
	• Elections made during the 3 months prior to beneficiary's entitlement to Medicare parts A and B are effective the first date of entitlement.	• Elections cannot be made prior to the first date of eligibility. Generally, elections made within the 60-day window posteligibility are effective the first day of the first pay period after the agency personnel office receives the enrollment request and follows a period during which the enrollee was in pay status.
	• Elections made during the annual election period are effective January 1.	• Employees: Initial enrollments made during the annual open season are effective the first day of the first pay period that begins in the following year and that follows a pay period during any part of which the enrollee was in pay status. Changes in enrollments made during the annual open season are effective the first day of the first pay period that begins the following year.
		• Retirees: Enrollments made during open season are effective January 1.
	• At other times, the effective date is the first day of the month after HMO receives the complete enrollment form.	• Effective dates vary for employees and retirees enrolling during special circumstances, such as when a health plan terminates its participation in FEHBP.

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Topic	M+C requirements	FEHBP requirements
Enrollment and disenrollment forms and notifications		
Enrollment forms	Beneficiaries must submit enrollment forms to HMO.	FEHBP employees submit enrollment forms to the agencies.
	HMO is not required to use a standard enrollment form. CMS provides three model enrollment forms that HMO may choose to use: • the individual enrollment form, • the employer group health plan (EGHP) enrollment form, or • the short enrollment form (for beneficiaries switching health plans within an HMO).	Employees: Employees must complete a standard form to enroll or change enrollment to another health plan. Retirees: Retirees must use an automated telephone system or Web site to change enrollment to another health plan.
	If HMO chooses to use its own enrollment form, the form must include data elements specified by CMS. CMS also requires that certain statements appear in the HMO enrollment form (to which the beneficiary need agree). For example, the enrollment form must state that the beneficiary understands that enrollment in more than one health plan with the same effective date will cancel all enrollments.	HMO may not require completion of its own enrollment or application form. HMO's electronic reproduction of enrollment form must contain the same data elements as the standard form.
	CMS must review HMO enrollment forms prior to their use. If HMO uses model enrollment forms without modifications, CMS is required to review them within 10 days of submission. If HMO chooses to use its own enrollment forms, CMS is required to review them within 45 days of submission.	No applicable requirements.
Notifications for other enrollment-related situations	CMS requires HMO to provide notifications to applicants in certain situations. For example, HMO must send applicants a written notice confirming receipt of a complete enrollment form and a confirmation when CMS has made the final determination of eligibility. Model forms are available from CMS for these required communications. HMOs must also provide identification cards to enrollees.	OPM requires HMO to send identification cards to new enrollees.

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Topic	M+C requirements	FEHBP requirements
Forms and notifications for voluntary disenrollment	M+C enrollees disenroll from health plans by changing to another health plan or by contacting the Social Security Administration, a Railroad Retirement Benefits office, CMS, or the HMO. When CMS notifies HMO that a beneficiary has disenrolled from its health plan, HMO must send its former enrollee a notice confirming the disenrollment. If HMO receives a verbal request from an enrollee, HMO must either ask for the request in writing or send the enrollee a disenrollment form and an accompanying letter. Once HMO receives either a written request or the completed disenrollment form, HMO must send a copy of the request and disenrollment letter to the former enrollee. Model forms and letters are available from CMS for all these required communications.	FEHBP enrollees disenroll from health plans by either changing enrollment to another health plan or canceling enrollment in FEHBP. Employees disenroll with the standard form or electronically. Retirees disenroll through a toll-free telephone number or an automated system.
Notifications for other disenrollment-related situations	CMS also requires HMO to provide notification to enrollees in other disenrollment-related situations. For example, HMO must send written notification to the enrollee upon deciding to disenroll the enrollee due to failure to pay premiums. CMS provides a model letter for this purpose. HMO must also send an enrollee a written notice if it terminates or withdraws from the enrollee's service area or continuation area–a CMS-approved area outside of the HMO's service area where the HMO provides, or arranges to provide, services to existing enrollees–will no longer include the area where the enrollee lives. CMS does not provide a model notification for this purpose.	No applicable requirements.

[a]We use the term "enrollee" to refer to a Medicare beneficiary who has already enrolled in an M+C health plan.

Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials.

Health Plan Enrollment Opportunities for M+C and FEHBP Beneficiaries

Before 2002, a beneficiary in FFS or an M+C health plan could enroll, on a monthly basis, into any M+C health plan accepting new enrollments or switch from an M+C health plan to FFS. BBA included an enrollment lock-in provision, effective January 1, 2002, that limited the number of opportunities, called election periods, for beneficiaries to make such changes (see table 3).[35] Once a beneficiary used an election period to enroll in a health plan, he or she was locked into that health plan until eligible for another election period. All beneficiaries were eligible for at least two election periods per year—one during the annual election period in November and a second during the first 3 months of the benefit year (6 months in 2002). However, the number of election periods each year was higher for beneficiaries with certain characteristics. For example, beneficiaries enrolled in a health plan on their 65th birthday had four election periods during their first 12 months in the program. Institutionalized beneficiaries could change health plans an unlimited number of times throughout the year.

On June 12, 2002, the Bioterrorism Act was signed into law. This act temporarily lifted the enrollment lock-in provision that had been implemented as of January 1, 2002; the lock-in provision is scheduled to be reinstated beginning January 1, 2005.[36]

Employees and retirees enrolled in FEHBP generally may change health plans one time each year, during the annual open enrollment period. However, FEHBP does permit changes at other times under certain circumstances, such as a change in family status (see table 4).

[35]BBA, Pub. L. No. 105-33, §4001, 111 Stat. 251, 281-283.

[36]Bioterrorism Act, Pub. L. No. 107-108, §532(a), 116 Stat. 594, 696.

Table 3: Opportunities for Medicare Beneficiaries to Enroll in an M+C Health Plan or Make Health Plan Changes Under M+C's Lock-in Provision

Election period	Length of election period	Are health plans required to be open to new enrollment?
First year of eligibility		
Initial coverage election	3 months prior to eligibility for Medicare parts A and B	Yes, unless at capacity
Open enrollment for newly eligible individuals; one change is allowed[a]	6 months posteligibility in 2005 3 months posteligibility in 2006 and beyond	No
Annual election	November	Yes, unless at capacity
Open enrollment; one change is allowed	January-June in 2005 January-March in 2006 and beyond	No
Special opportunity for beneficiaries aged 65 to return to FFS	1 year following enrollment within Medicare's initial enrollment period at 65th birthday	Not applicable
After first year of eligibility		
Annual election	November	Yes, unless at capacity
Open enrollment; one change is allowed	January-June in 2005 January-March in 2006 and beyond	No
Election periods for special circumstances		
Beneficiary moves out of health plan's service area or continuation area	Includes the month prior to the move, the month of the move, and the month after the move	Yes, unless at capacity
Beneficiary's health plan discontinues service	Varies depending on circumstance	Yes, unless at capacity
Beneficiary is living in an institution	Year-round	No
Beneficiary's health plan violates contract	Varies depending on circumstance	Yes, unless at capacity
Beneficiary enrolled in an EGHP	When an individual in the EGHP makes an election	Yes, unless at capacity
Exceptional conditions as determined by CMS	Specified by CMS	Yes, unless at capacity

[a]However, in 2005 and beyond, the election period must not extend past December 31 of the same calendar year.

Source: GAO summary of information provided by CMS, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials.

Table 4: Opportunities for FEHBP Beneficiaries to Enroll in a Health Plan or Make Health Plan Changes

Election period	Length of election period	Are health plans required to be open to new enrollment?
First year of eligibility		
Initial opportunity to enroll	Within 60 days after becoming eligible, generally after beginning federal employment[a]	Yes
Annual open season	Designated by OPM; the open season for 2002 was conducted November 12 to December 10, 2001	Yes
After first year of eligibility		
Annual open season	Designated by OPM; the open season for 2002 was conducted November 12 to December 10, 2001	Yes
Election periods for special circumstances		
Beneficiary, or covered family member, in an HMO moves or becomes employed outside of the service area from which the HMO accepts enrollments	Upon notifying the federal agency that hired the beneficiary of the move or change of place of employment	Yes
Beneficiary's health plan discontinues service	During annual open season, unless OPM designates a different period of time	Yes
Other, such as: change in employment change in family status	Varies by circumstance	Yes

[a]Agencies may allow employees to make late elections if employees demonstrate they missed the original deadline due to causes beyond their control. Employees make a request to their agency, and if the request is granted, they have 60 additional days from the date the request was granted to make an election.

Source: GAO summary of information provided by OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials.

Marketing and Enrollee Communication Materials

M+C, FEHBP, NAIC, NCQA, and JCAHO have HMO requirements that pertain to marketing and enrollee communication materials. Our summary of those requirements is organized as follows.

Types of Materials Subject to Standards

- Advertising and prospective member materials
- Materials that explain HMO operations

Approach Used to Ensure that Materials Conform to Standards

- Prior approval
- Postdistribution review
- Ongoing assessment of new members' understanding of HMO operations

Standards for Documents and Information

- Preenrollment documents related to benefits and coverage
- Deadline for distributing preenrollment documents
- Postenrollment documents related to benefits and coverage
- Deadline for distributing postenrollment documents
- Standard language and formats
- Model language and formats
- Guidelines for preparing materials
    - Language phrases
    - Readability
    - Producing materials in other languages and formats
    - Telephone numbers

- References to statistical studies
- References to competitors
- References to outpatient prescription drug benefit

Standards for Marketing Activities

- Promotional activities
- Prohibited activities
- Items not covered in contract

Review of Materials

- Reviewing officials
- Frequency of review
- Timing of review
- Time frames for standard review
- Time frames for expedited review
- Final verification of beneficiary notification materials
- Annual certification of compliance in preparing marketing materials

Table 5 summarizes selected M+C, FEHBP, NAIC, JCAHO, and NCQA requirements for marketing and enrollee communication materials.

Table 5: Selected Requirements for Marketing and Enrollee Communication Materials, M+C, FEHBP, NAIC, JCAHO, and NCQA

Topic	M+C requirements	FEHBP requirements
Types of materials subject to standards		
Advertising and prospective member materials	Advertising and prospective member materials intended primarily to attract or appeal to eligible nonenrolled beneficiaries and to promote membership retention, such as the following: • all advertisements (print, radio, television, Internet), Web site contents, outdoor advertising (billboards, signs attached to transportation vehicles); • direct mail pieces; • summary of benefits; and • prepared sales talks or presentation flyers.	Advertising and prospective member materials intended to describe an HMO's benefits, limitations, exclusions, and how to access care, such as the following: • a standardized brochure produced by each HMO, the FEHBP brochure, that is a complete description of the HMO's benefits, limitations, and exclusions; and • all other materials, considered supplemental to the FEHBP brochure, such as circulars and leaflets.
Materials that explain HMO operations	Notification materials used to communicate with the enrollee about membership policies and procedures and coverage, such as the evidence of coverage, the member handbook, wallet card instructions, enrollment/disenrollment-related notices and forms, claims denial notices, provider termination notices, and provider directory.	Materials, such as the FEHBP brochure, provider directories, and forms for selecting a physician.
Approach used to ensure that materials conform to standards		
Prior approval	Required except for employer group health plan marketing materials.	Required for HMO's FEHBP brochure.
Postdistribution review	Selective review, on a sample basis, occurring during monitoring compliance site visits, spot checks of media advertisements, or in response to complaints.	Selective review, on an ongoing basis, of all other materials that must comply with OPM and NAIC guidelines.
Ongoing assessment of new enrollees' understanding of HMO operations	No applicable requirements.	No applicable requirements.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
Advertising and prospective member materials intended to sell insurance policies, such as the following: • printed and published material, audiovisual material, direct mail, newspapers, magazines, radio and television scripts, Web sites and other Internet displays or electronic communications, billboards or similar displays; • descriptive literature, such as circulars, leaflets, booklets, depictions, illustrations, and form letters; • prepared sales talks or presentations; and • materials included with a delivered policy, renewal, or reinstatement notices.	No applicable standards.	Prospective member materials intended to describe an HMO's benefits and procedures, such as the following: • promotional brochures, summary of benefits, provider directories, scripts for verbal presentations, and media advertisements.
Materials, such as an evidence of coverage or contract, that explain the benefits to be provided.	Written information, such as an overview of the HMO to orient enrollees; description of HMO and its services, components, clinical staff, and licensed independent practitioners; how to access HMO services; how to access emergency services; and description of the scope of benefits and the circumstances under which those benefits may be provided.	Materials that describe benefits and HMO operations, such as the member handbook, identification card, benefit summaries, participating provider handbook, and member newsletter.
Can be required.	No applicable standards.	No applicable standards.
Can be required.	Required as part of on-site accreditation survey that takes place at least once every 3 years.	Required as part of on-site accreditation survey that takes place at least once every 3 years. Surveyors review, on-site, the materials actually in use.
No applicable requirements.	No applicable standards.	HMO must have systematic and ongoing processes for assessing how clearly new enrollees understand HMO policies and procedures, and for preventing any identified misrepresentations made to new enrollees from occurring in the future.

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Topic	M+C requirements	FEHBP requirements
Standards for documents and information		
Preenrollment documents related to benefits and coverage	Summary of benefits describes an HMO's benefit package(s) and enrollee costs, compared to fee-for-service.	The FEHBP brochure is a complete description of the HMO's statement of benefits, limitations, exclusions, and how to access care.
Deadline for distributing preenrollment documents	HMO had to begin marketing 2003 benefits as of September 9, 2002. Current enrollees must receive the annual notice of change, with the summary of benefits, by October 30, 2002.	For 2003, HMO must send its FEHBP brochure to federal agencies for receipt no later than October 14, 2002, so it could be distributed to prospective members.
Postenrollment documents related to benefits and coverage	Provider directory and the evidence of coverage, which describes the rights and responsibilities of a Medicare beneficiary as an enrollee of a Medicare HMO. Annual notice of change describes the specific changes in benefits, premiums, and HMO rules that will be in effect for the next contract year.	Provider directory and the FEHBP brochure, which is a complete statement of benefits, limitations, exclusions, and how to access care. It is part of OPM's contractual arrangement with an HMO. The contents of the FEHBP brochure are similar to the combined contents of three M+C documents: the summary of benefits, evidence of coverage, and annual notice of change.
Deadline for distributing postenrollment documents	For 2003, current enrollees must receive the evidence of coverage by March 1, 2003. Enrollees receive a provider directory at the time of enrollment and annually thereafter.	Each current enrollee must receive a FEHBP brochure and provider directory annually prior to start of the open season; for 2003 the open season will start November 11, 2002. HMO must state in the FEHBP brochure if its provider directory is available on its Web site.
Standard language and formats	Required standard language and format for the summary of benefits, the notice of denial of medical coverage, and notice of denial of payment. Employer group health plans are exempted from using a standardized summary of benefits.	Required standard language and format for the FEHBP brochure.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No required documents but HMO's advertising materials must include the type of policy offered. HMO prohibited from expressing limitations, exceptions or reductions, or conditions of renewability in a way that obscures or minimizes them. HMO prohibited from using language that will cause fear or hope of financial gain.	No required documents.	No required documents, but HMO's marketing materials and presentations must include accurate descriptions of its covered benefits, practitioner and provider availability, pharmaceutical management procedures, and exceptions and limitations. At least one marketing piece must describe the scope of utilization management activities.
No applicable requirements.	No applicable standards.	No applicable standard, but surveyors review, on-site, the materials actually in use to inform prospective members about the HMO.
Provider directory and evidence of coverage, or individual contract, which must contain clear statements on various HMO activities and operations, including an explanation of the benefits to be provided under the contract and the circumstances under which those benefits may be provided.	List of participating licensed independent practitioners and their qualifications and list of clinical staff and their qualifications. Enrollees should also receive written information needed to access HMO services and emergency services, the scope of benefits and the circumstances under which those benefits may be provided, rights and responsibilities, and the HMO's authorization and treatment processes.	Provider directory and instructions on how enrollees can request by telephone information on any provider professional qualifications not included in the directory, such as medical school attended and residency completed. Enrollees should also receive written information needed to understand benefit coverage and obtain care, and their rights and responsibilities.
Each enrollee must receive an evidence of coverage upon enrollment. HMO must make written copies of provider directories available to individuals upon enrollment, reenrollment, and at other times upon request.	HMO must inform enrollees in a "timely manner" (according to its own or industry standards, or state and federal guidelines, as applicable).	Each enrollee must receive written information on rights and responsibilities at enrollment, and when policy changes occur.
Format and content of an advertisement should be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. In advertisements, limitations, exceptions, or reductions in benefits must be clearly disclosed in close conjunction with the description of benefits or under appropriate and prominent captions.	No applicable standards.	No applicable standards.

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Topic	M+C requirements	FEHBP requirements
Model language and formats	HMO can expedite the marketing review process by voluntarily using CMS' model language and formats, without modification, as these CMS materials meet the marketing requirements. HMO is not required to use these models. Available models of forms developed by CMS for HMO use include: • evidence of coverage, • annual notice of change, • enrollment notices, • disenrollment notices, and • enrollment form.	No applicable requirements.
Guidelines for preparing materials		
Language phrases	HMO must adhere to guidelines regarding "must use," "can use," and "can't use" phrases.	HMO must include specific phrases in advertising and supplemental materials when presenting benefit or rate information outside the context of the FEHBP brochure, and follow guidelines on how the information is presented. HMO must also follow NAIC guidelines.
Readability	HMO must, but is not limited to, the following: • use a minimum 12-point font, with Times New Roman as the standard for measuring font size; • place footnotes consistently in same place; and • in all nonnotice materials (e.g., television advertisements), make the footnote the same size as the message designed to capture the reader's attention.	HMO should use the OPM *Plain Language Guide* for guidance in style, usage, and format, such as using common words and limiting the use of acronyms.
Producing materials in other languages and formats	HMO must make enrollee materials available in the primary language(s) of major population groups served (groups that constitute more than 10 percent of the population in a defined geographic area). HMO must also make enrollee materials available, except provider directory, in large print and Braille formats or through recorded cassettes. HMO submits to CMS the non-English or Braille version, the English version, and a letter of attestation that all versions convey the same information.	HMO, at OPM's direction, must produce and distribute an audio cassette version of the approved FEHBP brochure language.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	No applicable standards.	No applicable standards.
HMO prohibited from using certain phrases that could be misleading, deceptive, or unfair.	No applicable standards.	No applicable standards.
HMO should, but is not limited to, the following: • use a minimum 10-point font, one point leaded, except for specification pages, schedules, and tables; • provide a table of contents or an index for policies that exceed 3,000 words or 3 pages; and • achieve a minimum required score on a Flesch or comparable reading ease test.	No applicable standards.	No applicable standards.
State insurance commissioner can require HMO to certify that any non-English language policy or form is translated from an English language policy or form that meets readability standards.	HMO, and its components and other clinical care sites, should demonstrate respect for its enrollees by communicating in a language understood by the enrollee (such as, verbal and written communications are conducted in the primary language and at the level of comprehension of the enrollee whenever possible, either directly or through translation) and addressing the needs of the hearing and speech impaired.	HMO must operate a translation service within its member services telephone function based on data on the linguistic needs of its enrollees.

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Topic	M+C requirements	FEHBP requirements
Telephone numbers	HMO must provide contact information in the summary of benefits, such as the HMO phone number and TTY/TDD phone number. HMO must list the hours of customer service each time a customer service phone number appears. HMO must list TTY/TDD numbers and hours of operation, in the same font size and style, when appearing with the HMO phone number. The font size and style rule is required for all media with the exception of television advertisements.	HMO must list its telephone number, address, fax number, and Web site address in the FEHBP brochure.
References to statistical studies	HMO can reference the results of studies or statistical information about enrollee satisfaction and quality. However, HMO must specify at a minimum the data source, dates, sample size, and number of HMOs surveyed.	HMO must follow NAIC guidelines.
References to competitors	HMO prohibited from using superlatives, such as highest or best, unless such superlatives can be substantiated by ratings. HMO also prohibited from making unsubstantiated comparisons with other HMOs and directing negative statements at other HMOs.	HMO must agree not to use advertising that is misleading or deceptive or makes incomplete, inappropriate, or disparaging comparisons. HMO prohibited from comparing benefits or operations to any other HMO or listing rates of other HMOs in its supplemental materials. HMO must also follow NAIC guidelines.
References to outpatient prescription drug benefit	If applicable, HMO must provide in its evidence of coverage whether or not it uses drug formularies or preferred lists. If so, the evidence of coverage must clearly explain key elements of the drug formulary. HMO's preenrollment marketing materials must disclose whether a formulary or preferred list is used and that the formulary or list may change during the contract year, as well as provide a contact number that the prospective member can call for more information.	HMO's FEHBP brochure must explain prescription drug coverage and, if applicable, key features of its drug formularies.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	No applicable standards.	No applicable standards.
HMO's statistical information must reflect accurately all current and relevant facts. HMO must identify the source of any statistics. HMO prohibited from using irrelevant facts.	No applicable standards.	No applicable standards.
HMO prohibited from using advertisements that directly or indirectly make unfair or incomplete comparisons of policies or benefits or make comparisons using noncomparable policies of other HMOs. HMO prohibited from disparaging competitors.	No applicable standards.	No applicable standards.
HMO's group or individual contracts or an evidence of coverage filed with the contract must contain a clear statement or description of formulary procedures for obtaining a listing of drugs on the formulary (if applicable).	No applicable standards.	HMO must describe its pharmaceutical management processes. If coverage of pharmaceuticals is restricted, HMO must describe: • how to obtain a copy of the pharmaceutical management procedures or check on the coverage of a specific nonformulary pharmaceutical; • extent to which access to specific pharmaceuticals is restricted; and • how enrollee can receive coverage for a pharmaceutical not on the formulary.

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Topic	M+C requirements	FEHBP requirements
Standards for marketing activities		
Promotional activities	HMO must follow CMS guidelines for conducting promotional activities, including, but not limited to the following: • allowing gifts to prospective members or enrollees with a nominal value of $15 or less based on retail purchase price; • permitting HMO to conduct health fairs that must be primarily social events where sales presentations and acceptance of enrollment forms are prohibited (with the exception of employer group health fairs); and • permitting providers to advise beneficiaries regarding enrollment, but not take enrollment applications in locations where direct medical care is provided.	HMO must follow NAIC guidelines.
Prohibited activities	HMO prohibited from: • giving cash or other monetary rebates as inducement for enrollment; • conducting marketing activities that could mislead or confuse Medicare beneficiaries; • engaging in any discriminatory marketing activities, such as recruiting upper-income Medicare beneficiaries and not low-income Medicare beneficiaries or soliciting door-to-door; and • using a health plan name that suggests that a health plan is not available to all Medicare beneficiaries.	HMO must follow NAIC guidelines.
Items not covered in contract	HMO can market items/services not covered in their M+C contracts, but with such restrictions as the following. • HMO must describe as value-added items and services (VAIS), not as benefits. • HMO must state that VAIS are not subject to the M+C appeals process. • HMO can also market multiple lines of business to Medicare beneficiaries, as long as it follows specific CMS guidelines, such as allowing current enrollees to decline receiving such communications.	HMO can market items and services not covered in their FEHBP contracts, but with such restrictions as the following. • HMO's non-FEHBP benefits must be health related. • HMO must describe the non-FEHBP benefits in the FEHBP brochure, limited to one page. • HMO must state that non-FEHBP benefits are not subject to FEHBP's disputed claims process.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
HMO may offer an initial premium that is lower than the full premium, but the lower initial premium may not be more prominently displayed in an advertisement than the full premium.	No applicable standards.	No applicable standards.
HMO prohibited from: • conducting marketing activities that involve knowingly making any misleading representation or incomplete or fraudulent comparisons of insurance policies or using high-pressure tactics; • implying that a contract, unless it is fact, is an introductory, initial, or special offer; is limited to a certain number of people; or is available for a limited time; • implying in any way that it is endorsed or affiliated with a municipal, state, or federal government entity; and • giving through style, arrangement, and overall appearance, undue prominence to any portion of text, any endorsements, or riders.	No applicable standards.	No applicable standards.
No applicable requirements.	HMO must inform enrollees about how to obtain health care services not covered in the HMO's benefit package.	HMO must accurately describe to prospective members services not covered in the HMO's benefit package.

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Topic	M+C requirements	FEHBP requirements
Review of materials		
Reviewing officials	Generally, regional CMS staff responsible for HMOs in a geographic area. HMO with a national presence can request a coordinated review of its materials, designating a lead regional office.	Centrally located OPM contract specialists assigned to FEHBP HMOs.
Frequency of review	HMO's materials and enrollee communications reviewed on an on-going basis.	HMO's FEHBP brochure annually reviewed by OPM; OPM selectively reviews all other materials on an on-going basis.
Timing of review	Review occurs prior to use. CMS may also conduct review as part of a regularly scheduled monitoring site visit; during a spot check of marketing pieces used in the media; or in response to a complaint.	Review occurs prior to use of the FEHBP brochure. All other materials are reviewed on an as-needed basis, such as in response to enrollee and HMO complaints.
Time frames for standard review	HMO must submit materials to CMS at least 45 days prior to distribution for approval. If CMS has not disapproved the materials within the 45-day period, then the HMO's materials are deemed approved. If CMS disapproves the material, another 45-day cycle begins when the HMO resubmits the corrected material.	OPM annually reviews and approves an HMO's FEHBP brochure. For 2003, the following schedule was in effect. • On July 2, 2002, OPM released an electronic version of the standardized FEHBP brochure that HMOs could modify to reflect their benefits and operations. • By August 8, 2002, OPM contract specialists and the HMOs had finished negotiating benefit changes for 2003. OPM sent an electronic version of the agreed-to FEHBP brochure text back to the HMO to put into the standardized format.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
Insurance commissioner.	A team of JCAHO surveyors performs on-site review; JCAHO committee makes all final accreditation decisions.	A team of NCQA surveyors, including physician and administrative reviewers, performs on-site review; NCQA committee of external senior physicians makes all final accreditation decisions.
HMO's advertising materials reviewed by insurance commissioner at regular and periodic intervals.	Frequency of review varies, depending on HMO's accreditation status. An on-site JCAHO accreditation survey occurs at least once every 3 years.	Frequency of review varies, depending on HMO's accreditation score. An on-site NCQA accreditation survey occurs at least once every 3 years. Surveyors review, on-site, the materials actually in use.
Review can occur prior to use, at the discretion of the insurance commissioner.	Review occurs after the use of materials. (This is because materials are reviewed on-site during a survey.)	Review occurs after the use of materials. (This is because materials are reviewed on-site during a survey.)
Insurance commissioner can require filing of advertising pieces for review no fewer than 30 days prior to use. State can require one of two options—prior approval or "file and use"—for review of contract forms and evidence of coverage. • Prior approval. HMO must file contract forms and evidence of coverage with the insurance commissioner at least 30 days prior to delivery or issuance, which can be extended for an additional 30 days during the initial 30-day review period. Contract forms and evidence of coverage deemed approved if no action taken. At any time, after 30 days notice and for cause shown, the insurance commissioner may withdraw approval of a form, effective at the end of the period. If insurance commissioner disapproves a form or withdraws approval of a form, HMO can request a hearing. • File and use. HMO must file contract forms and evidence of coverage with the insurance commissioner at least 30 days prior to delivery or issuance. At any time, after its issuance and delivery and for cause shown, the insurance commissioner may disapprove the form; this disapproval becomes effective 30 days after HMO receives notice from the insurance commissioner. HMO can request hearing.	Review of materials given to enrollees occurs on-site during JCAHO's accreditation survey of HMO that occurs at least once every 3 years.	Review of materials occurs on-site during NCQA's accreditation survey of HMO that occurs at least once every 3 years.

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Topic	M+C requirements	FEHBP requirements
Time frames for expedited review	CMS has 10 days to review any materials where an HMO follows CMS model language without modification.	No applicable requirements.
Final verification of beneficiary notification materials	HMO's beneficiary notification materials are subject to a final verification review process, where CMS reviews the materials at the final proof stage (such as a camera-ready copy). The final verification review is conducted to confirm that the final proof version contains no changes from the initial text version that was approved by CMS.[a]	HMO's first print run of its final FEHBP brochures is subject to verification of accuracy; OPM obtains 20 FEHBP brochures to review.
Annual certification of compliance in preparing marketing materials	No applicable requirements.	No applicable requirements.

[a]For the 2002 and 2003 beneficiary education/open season campaigns, CMS has temporarily suspended final verification of beneficiary notification materials, including the summary of beneficiary notification materials, including the summary of benefits, the evidence of coverage, and all other materials prepared as part of HMO's enrollment package(s).

Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials. GAO summary of information provided by NAIC, JCAHO, and NCQA, including NAIC model requirements for HMOs, standards from the current JCAHO and NCQA accreditation manuals for HMOs, and interviews with NAIC, JCAHO, and NCQA officials.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	No applicable standards.	No applicable standards.
No applicable requirements.	No applicable standards.	No applicable standards.
HMO can be required by insurance commissioner to file a certificate of compliance stating that advertising materials disseminated during the preceding year complied or were made to comply with the regulations or insurance laws of the state.	No applicable standards.	No applicable standards.

Quality Improvement

M+C, FEHBP, NAIC, JCAHO, and NCQA have HMO requirements that pertain to quality improvement (QI). Our summary of those requirements is structured along the following dimensions.

Elements of a Quality Improvement Program

- Purpose
- Performance improvement projects
- Annual performance measurement

Administration of Quality Improvement Program

- Leadership involvement
- Organizational structure
- Program documentation
    - Program description
    - Meeting documentation
    - Annual work plan
    - Evaluation report
- Provider participation
- Enrollee participation
- Accreditation

Performance Improvement Projects

- Number of projects
- Choice of project topics
- Choice of quality measures

- Required results
  - Minimum performance levels and benchmarks
  - Demonstrable performance improvement
  - Sustained performance improvement
- Evaluation
  - How HMO reports
  - Who evaluates
  - What is evaluated
  - Potential actions based on evaluation

Annual Performance Measurement

- Clinical and administrative performance
  - Who participates
  - How data are externally validated
  - Who pays for external validation
  - When annual data are submitted
- Member satisfaction survey measures for current enrollees
  - Who participates
  - Who is sampled
  - Who pays for survey administration
- Member satisfaction survey measures for disenrolled members
  - Who participates

  - Who is sampled
  - Who pays for survey administration
- Member health status survey measures
  - Who participates
  - Who is sampled
  - Who pays for survey administration

Table 6 summarizes selected M+C, FEHBP, NAIC, JCAHO, and NCQA requirements for QI.

Table 6: Selected Requirements for Quality Improvement for M+C, FEHBP, NAIC, JCAHO, and NCQA

Topic	M+C requirements	FEHBP requirements
Elements of a quality improvement program		
Purpose	HMO must operate an ongoing quality assessment and performance improvement (QAPI) program that meets M+C requirements.[a] HMO's QAPI program must, for example, stress health outcomes; monitor and evaluate high volume and high risk services and care of acute and chronic conditions; evaluate the continuity and coordination of care provided to enrollees; measure enrollee satisfaction; use written protocols to review utilization; identify areas in which quality can be improved; take actions to improve quality; and assess the effectiveness of such actions through systematic follow-up.	HMO must operate an internal quality assurance program that meets FEHBP requirements. HMO's internal quality assurance program must, for example, measure and collect data on the quality of health care services delivered to its enrollees; reduce medical errors; measure enrollee satisfaction; meet minimum contractual performance standards (such as timeliness of telephone responses and timeliness of appointments); and correct any identified deficiencies.
Performance improvement projects	HMO must conduct QAPI projects as part of an overall QAPI program. HMO's QAPI projects implement system interventions intended to improve performance in clinical and nonclinical areas. HMO must evaluate and validate the results of the interventions and determine the need for further action.	HMO, as part of its internal quality assurance program, must take into account the published results of its annual member satisfaction survey, as well as any other results as directed by OPM, in identifying areas for improvement.
Annual performance measurement	HMO must annually collect and report data on performance measures specified by CMS, including measures pertaining to a national topic and the Health Plan Employer Data and Information Set (HEDIS).[d] HMO must also conduct standardized member satisfaction and member health status surveys.	HMO must annually collect and report data on performance measures specified by OPM, including a subset of HEDIS measures, and conduct a standardized member satisfaction survey.
Administration of quality improvement program		
Leadership involvement	HMO's policy-making body, such as the governing board or a committee of senior executives, must be involved in the QAPI program. At a minimum, HMO's policy-making body must approve the initial written QAPI program description, and any subsequent changes, and annual work plan; review the annual evaluation and take action on any resulting recommendations; and receive and review periodic reports on QAPI activities.	No applicable requirements.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
HMO must operate an organizational QI program for designing, measuring, assessing, and improving the processes and outcomes of health care delivered to its enrollees.	HMO must use a systematic performance improvement approach to improve enrollee health outcomes throughout the HMO by improving the performance of clinical, governance, and support processes.	HMO must operate a comprehensive QI program to improve the quality and safety of clinical care and the quality of service delivered to its enrollees.
HMO must conduct QI activities as part of an overall QI program.[b] HMO's QI activities implement strategies intended to improve both care delivery and health outcomes. HMO must evaluate the results of its improvement strategies to determine the need for further action.	HMO must conduct performance improvement activities as part of an overall performance improvement approach.[c] HMO's performance improvement activities implement changes to the HMO's clinical, governance, and support processes that improve health outcomes or reduce the risk of serious medical errors. HMO must evaluate results to determine the need for further action.	HMO must conduct QI projects as part of an overall QI program. HMO's QI projects implement interventions to improve quality of care and service. HMO must evaluate and validate the results of its QI projects to determine the need for further action.
HMO must collect and analyze information specific to its enrollees, including documentation of enrollee satisfaction, as specified in its written description of annual activities.	HMO must collect data on an ongoing basis and display the analysis of data in monthly data points for 30 measures it selects to monitor. HMO must regularly, not necessarily annually, measure, assess, and use information about enrollee needs and satisfaction to improve member services; HMO must determine the frequency and detail of this data collection.	HMO must annually collect and report data on performance measures specified by NCQA, including a subset of HEDIS measures, and conduct a standardized member satisfaction survey.
HMO's Chief Medical Officer or Clinical Director has primary responsibility for implementing the QI program, including approving and periodically reviewing a written program description and, at least semiannually, reviewing reports of QI activities undertaken.	HMO's leaders must select and effectively use a performance improvement approach.	HMO's QI program must be accountable to a governing body. At a minimum, the HMO's governing body must review and approve the QI program description.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Organizational structure	A senior HMO official must administer the QAPI program. HMO must clearly identify individuals or organizational components responsible for each QAPI activity and the organizational structures in place to assure communication and coordination. HMO must hold administrative QAPI meetings at regularly scheduled intervals (as defined in its policies and procedures); meetings must be adequately attended.	No applicable requirements.
Program documentation Program description	HMO must have a written QAPI program description that shows the role, structure, staffing, and function of each organizational component, and the interrelations among components for each aspect of the QAPI program.	No applicable requirements; however, HMO, as directed by OPM, must submit its progress in meeting specific OPM requirements, such as implementing a patient safety program.
Meeting documentation	HMO must document that it appropriately follows up on issues raised in QAPI meetings.	No applicable requirements.
Annual work plan	HMO must have a written annual QI work plan.	No applicable requirements.
Evaluation report	HMO, at least annually, must formally evaluate the effectiveness of its QAPI program strategy. HMO must evaluate the timeliness of annual work plan activities, whether additional resources need to be committed, and potential recommendations for changes in program strategy or administration.	HMO must furnish to OPM semiannual quality assurance reports.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
Chief Medical Officer or Clinical Director must administer HMO's QI program. HMO may use a quality committee to perform its QI activities.	HMO's leaders must set performance improvement program expectations, develop plans, and manage program implementation. HMO's performance improvement activities must be collaborative and involve all appropriate HMO personnel, clinical staff, and licensed independent practitioners.	A designated physician and a behavioral health practitioner must be substantially involved in the implementation of HMO's QI program. HMO must have a QI committee to oversee, and be involved in, QI activities. Multiple parts of the HMO, including its leadership, participate in the QI program.
HMO must file with the insurance commissioner a written QI program description of the objectives, lines of authority and accountability, evaluation and data collection tools, performance improvement activities, and annual effectiveness review.	No applicable standards.	HMO must have a written QI program description that specifies the structure and content of the QI program. The description must specifically address behavioral health care and activities to improve patient safety. It must also state the role and function of any QI committee.
No applicable requirements.	No applicable standards.	HMO's QI committee must maintain contemporaneous minutes, dated and signed, that demonstrate meaningful review of, and advice for, QI activities and reporting.
HMO must have a written description of QI activities to be conducted, such as the diagnoses and treatments to be reviewed annually.	No applicable standards.	HMO must have an annual QI work plan, or schedule of activities, that includes: objectives, scope, and planned projects for the year; planned monitoring of previously identified issues; and planned evaluation of the QI program.
HMO must conduct an annual evaluation of the effectiveness of its QI program.	No applicable standard for written evaluation report. HMO must systematically aggregate and analyze performance improvement data on an ongoing basis and compare its performance over time and with other sources of information. HMO must identify changes that will lead to improved performance and reduce the risk of serious medical errors.	HMO must conduct an annual evaluation of its QI program and have the evaluation report approved by the accountable person or the QI committee. The written evaluation report must describe the completed and ongoing QI projects for the year and include data trends. It must also include a critical assessment of potential barriers to achieving each QI program goal. HMO must use the evaluation to determine whether to restructure or change its QI program for the subsequent year.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Provider participation	HMO must ensure that affiliated or employed providers actively participate in the design and implementation of the QAPI program. HMO must ensure that a group of clinicians actively participate in key activities, including: selecting and prioritizing QAPI projects, developing measures, analyzing study results, identifying and proposing solutions to problems, and aiding in communication of QAPI activities and results to other providers.	No applicable requirements.
Enrollee participation	HMO must establish a mechanism for obtaining enrollee input into the priorities for its QAPI program.	HMO must take into account the published results of its administered member satisfaction survey, as well as any other results as directed by OPM, in identifying areas for improvement as part of its internal quality assurance program.
Accreditation	HMO can meet specific M+C requirements if it obtains accreditation from a private organization approved by CMS. As of June 15, 2002, CMS had approved three private accreditation organizations—AAAHC, JCAHO, and NCQA.	HMO with 500 or more FEHBP enrollees, in 2002, must begin seeking accreditation from a nationally recognized, independent accrediting organization. OPM currently recognizes JCAHO, NCQA, or URAC/American Accreditation HealthCare Commission.
Performance improvement projects		
Number of projects	HMO must annually participate in a QAPI project chosen by CMS, referred to as the national QAPI project.[e] Starting in 2004, an HMO can participate in a local QAPI project, such as one initiated by a private purchaser group, a quality improvement organization (QIO) (formerly known as a peer review organization), or a state Medicaid agency, in place of the national QAPI project.[f]	No applicable requirements.
Choice of project topics	CMS selects the topic for the national QAPI project.[g] An HMO's local QAPI project must address one of nine focus areas defined by CMS for both mental and physical conditions.[h] Within a focus area, HMO must select local QAPI project topics that are relevant to the Medicare population.	No applicable requirements.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
HMO must ensure that participating providers have the opportunity to participate in developing, implementing, and evaluating the QI program. HMO must make available annually to providers findings from its QI program, including information about its progress in meeting internally established goals and, where available, externally established benchmarks.	HMO's leaders must provide for, and encourage, licensed independent practitioners to participate in its performance improvement activities. HMO's leaders and appropriate HMO personnel, clinical staff, and licensed independent practitioners work collaboratively on an HMO-wide basis to design and implement the HMO's performance improvement approach. HMO must monitor the needs, expectations, and views of licensed independent practitioners regarding current performance and opportunities for improvement.	HMO must ensure that its practitioners can actively participate in the QI program. These practitioners help educate the HMO's other practitioners and providers about the QI program, specific QI projects, and the results of these projects.
HMO must provide enrollees with the opportunity to comment on its QI program. HMO must make available annually to enrollees findings from its QI program, including information about meeting its internally established goals and, where available, externally established benchmarks.	HMO must continuously and systematically assess enrollee expectations of, and satisfaction with, care and services provided and use the information to improve services. HMO, consistent with its overall resources, must include enrollees in developing the services it offers.	HMO must obtain and act upon enrollee input for the QI program by conducting an annual member satisfaction survey.
State can consider accreditation by a recognized private accrediting organization as evidence of meeting some or all of its quality assessment and improvement requirements.	No applicable standards.	No applicable standards.
No applicable requirements.	JCAHO views performance improvement activities to be continuous and ongoing and does not specify the number of performance improvement activities to be conducted.	HMO must show meaningful improvement in at least four QI projects (two that address clinical quality of care and two that address service quality) to receive the highest accreditation score.
NAIC does not define explicit focus areas to be addressed. HMO, in selecting annual topics to review, must select practices and diagnoses that affect a substantial number of its enrollees.	JCAHO does not define explicit focus areas that must be addressed. HMO must collect data and monitor outcomes in clinical and nonclinical areas of care. HMO's criteria for selecting a performance improvement activity must consider whether the activity would affect a large percentage of enrollees; has the potential to place enrollees at risk if not implemented appropriately; has been, or is likely, to be prone to problems; or has significant cost implications.	NCQA does not define explicit focus areas to be addressed. HMO must conduct clinical and service QI projects that are important and relevant to a significant portion or subset of its enrollees. HMO may consider clinical issues identified in audited HEDIS measures as relevant for potential clinical QI projects and service issues identified in member satisfaction survey ratings as relevant for potential service QI projects.[i]

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Choice of quality measures	For national QAPI projects, HMO must use CMS specified quality measures. For a local QAPI project, HMO must use one or more quality measures to track its performance and improvement over time. HMO's quality measures must be objective, clearly and unambiguously defined, based on current clinical knowledge or health services research, and subject to objective measurement. HMO may adopt standard measures from outside sources or develop its own. HMO's local QAPI project must include some quality measures for which data are available that allow comparison of the HMO's performance to similar organizations or to local, state, or national norms.	No applicable requirements.
Required results Minimum performance levels and benchmarks	HMO must achieve required minimum performance levels or meet required benchmarks established by CMS on the standardized quality measures used in national QAPI projects.[j] HMO must compare its performance on the local QAPI project to prevailing standards in the community.	HMO must meet minimum contractual performance standards specified to ensure quality of service and responsiveness to enrollees.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
HMO must use a range of appropriate methods to analyze quality consistent with current medical research, knowledge, standards, and practice guidelines.	HMO must use performance improvement measures to determine if a process, component, or service is performing according to expectations and to monitor improvements in performance. HMO may use performance improvement measures it develops or adopts from external sources. HMO's criteria for selecting a performance improvement measure must include such factors as: measure has documented numerator and denominator statements; measure has defined data elements; and measure can detect changes in performance over time.	HMO must use explicit, defined quality measures that allow it to measure its performance. HMO's measures must be based on standards of care or practice that include objective clinical criteria that are based on authoritative sources, such as clinical literature.
HMO must establish its own performance expectations for the performance measures that it selects to monitor. HMO must compare QI program findings with its past performance, as appropriate, against internally established goals or, where available, externally established benchmarks.	HMO must establish its own performance expectations for the performance measures it monitors. HMO must compare its performance over time and with benchmarks from up-to-date external sources, such as recent scientific, clinical, and management literature; well-formulated practice guidelines or parameters; performance measures; and standards that are periodically reviewed and revised. HMO must use the comparisons to determine if its performance is unacceptable or excessively variable.	HMO must have an explicit, quantifiable performance goal (internally defined) or benchmark (externally defined) for each measure. HMO may use a benchmark from the industry best practice or the best performance within a corporate structure or a specific geographic area. Each goal and benchmark must be designated as a specific rate, such as the percentage of diabetic enrollees who received a retinal screening. HMO, as it refines its processes for delivering care and service, must move the performance goals and benchmarks toward optimal performance levels. HMO's actual results from required HEDIS clinical measures for Medicare enrollees, as well as the results of the standardized member satisfaction survey, are used in determining 27.5 percent of its accreditation score. HMO's actual HEDIS results are compared to national and regional benchmarks and thresholds. HMO's member satisfaction survey results are compared to national benchmarks and thresholds.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Demonstrable performance improvement	An HMO's QAPI projects must result in a demonstrable performance improvement, relative to preproject baseline measures. HMO must show that the improvement is meaningful to its Medicare enrollees and that the improvement can be reasonably attributed to the actions it has taken.	No applicable requirements.
Sustained performance improvement	Upon achieving demonstrable improvement, an HMO must sustain the performance improvement for at least 1 year.	No applicable requirements.
Evaluation How HMO reports	HMO must submit a Project Completion Report, developed by CMS, to report at least one quality measure and performance improvement.[k] In general, HMO must submit a CMS developed Project Completion Report 90 days after the QAPI project completion date.	No applicable requirements.
Who evaluates	HMO's QAPI projects must be reviewed by a CMS contractor, known as a Medicare+Choice Quality Review Organization (M+CQRO).[l] Review occurs off-site.	No applicable requirements.
What is evaluated	M+CQRO evaluates one quality measure for which an improvement has been achieved per QAPI project. M+CQRO scores each element of the HMO's performance against established QAPI requirements. The overall score is a weighted average based on the significance placed on each particular QAPI element.	No applicable requirements.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	HMO must define the desired improvements. HMO must identify the measures it will use to determine whether a change represents a performance improvement.	HMO must demonstrate that an improvement has occurred; is relevant to the HMO's population; affects a significant portion of the HMO's population or population at risk; is likely to result in a better health outcome for the HMO's population; is attributable to the strength, duration, and quality of the HMO's action(s) and not other confounding factors; and has an impact on high-volume, high-risk, or high-cost conditions or services.
No applicable requirements.	HMO must achieve and maintain its performance improvement. HMO must collect data for a period of time and frequency that permits it to ensure that improvement continues.	HMO must demonstrate meaningful improvement in 2 clinical QI projects and 2 service QI projects (from up to 10 submitted for evaluation). Each of the improvements must have occurred in the 3-year period covered by an accreditation survey and have been subsequently sustained.
HMO must make available annually, to providers and enrollees, findings from its QI program, including information about its progress in meeting internal goals and external standards, as applicable.	JCAHO regards performance improvement activities as ongoing processes and therefore does not require a beginning and end date. JCAHO surveyors review performance improvement activities on site during an accreditation survey that occurs at least once every 3 years.	HMO can complete the Quality Improvement Activity form, developed by NCQA, to report each completed QI project; HMO must provide the data requested in NCQA's form, even if it does not use NCQA's form. HMO can submit one or more measures for each QI project. HMO must submit completed Quality Improvement Activity forms to NCQA as part its accreditation survey application.
HMO must certify to the insurance commissioner annually that its QI activities and QI materials given to providers and enrollees meet all applicable requirements.	HMO's performance improvement activities must be reviewed by a team of JCAHO surveyors during an accreditation site visit that occurs at least once every 3 years. JCAHO committee makes all final accreditation decisions.	HMO's QI projects must be reviewed by a team of NCQA surveyors, including physicians and administrative reviewers, during an accreditation site visit that occurs at least once every 3 years. NCQA committee of external senior physicians makes all final accreditation decisions.
No applicable requirements.	HMO is scored on its performance against established JCAHO standards. JCAHO determines an HMO's total score, based on each standard's weight and predetermined formulas.	NCQA requires that an HMO show meaningful improvement on one quality measure per QI project. NCQA scores the HMO's performance against required elements. The overall scoring is a weighted average based on the significance placed on each particular element. HMO must meet all of NCQA's criteria for meaningful improvement for 4 evaluated QI projects (2 clinical and 2 service) to attain the highest accreditation score.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Potential actions based on evaluation	M+CQRO forwards to CMS a completed Project Review Report, developed by CMS, that includes the final score of the QAPI project and recommended corrective actions to address any identified deficiencies. CMS then gives final approval on any evaluation report. CMS then forwards the Project Review Report to the HMO—HMO does not communicate directly with the M+CQRO. CMS could terminate its M+C contract with an HMO if the HMO fails to implement an acceptable QAPI program. CMS may also specify special project topics and quality indicators if it determines that an HMO has not achieved sufficient diversity in its QAPI projects.[m]	OPM can hold up to 1 percent of premiums for not meeting contractual standards or can increase service charge (profit) based on meeting contractual standards, depending on how rates are set for the HMO.
Annual performance measurement		
Clinical and administrative performance	HMO, if it meets CMS's participation criteria, must report to NCQA patient-level and summary information for Medicare HEDIS measures specified by CMS; for 2001, HMOs had to report 23 Medicare HEDIS measures to CMS.[o] CMS receives the data from NCQA.	HMO must report a subset of HEDIS measures applicable to commercial enrollees. HMO must submit to NCQA summary and patient-level data of the HEDIS measures. OPM receives the data from NCQA.
Who participates	HMO, if it had • a Medicare contract as of January 1 of the HEDIS measurement year (the previous year) or earlier and • enrollees as of January 1 of the measurement year or earlier and at least 1,000 enrollees as of July 1 of the measurement year.	HMO with 500 or more enrollees. Any HMO reporting HEDIS data to NCQA for non-OPM purposes may use that HEDIS data to satisfy OPM requirements—HMO does not have to report separately on FEHBP enrollees only.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.[n]	JCAHO provides HMO with an accreditation decision in its Official Accreditation Decision Report. HMO may respond; if HMO responds it must do so within a designated time frame. HMO may appeal a JCAHO recommendation for accreditation denial, if done within JCAHO guidelines. If HMO is denied accreditation or receives provisional accreditation, it can follow JCAHO guidelines to have its case reviewed.	NCQA provides HMO with a preliminary Survey Report with findings and recommendations but no standard compliance designations. HMO may respond; if HMO responds it must do so within a designated time frame. An NCQA committee reviews all relevant documentation and issues compliance designations for each standard and makes an accreditation designation. NCQA forwards to HMO the final Survey Report. HMO may request that NCQA reconsider its findings from the on-site survey if done within NCQA guidelines. NCQA annually recalculates an HMO's accreditation status based on its submitted HEDIS results.
No applicable requirements.	JCAHO administers ORYX, a performance measurement initiative for HMOs with network accreditation. For 2001, HMO had to select and monitor 30 individual measures that best served its strategic management goals. HMO submits the measures to JCAHO with their accreditation survey application. Submission does not occur annually. JCAHO's next phase of the ORYX initiative for HMOs includes the identification of specific core performance measures, grouped into measurement sets.	HMO must annually report a subset of clinical HEDIS measures appropriate for the population it serves. HMO serving Medicare enrollees must have reported eight clinical HEDIS measures to NCQA for accreditation in 2001.
No applicable requirements.	HMO.	HMO with Medicare enrollees follows the same requirements as M+C.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
How data are externally validated	HMO must contract with an NCQA-certified HEDIS compliance audit organization and undergo a full HEDIS audit.[p] CMS releases summary HEDIS data in public use files.	HMO not required to have HEDIS 2001 data externally validated; OPM will not publicly publish data. OPM will require HEDIS 2002 data to be audited.
Who pays for external validation	HMO.	HMO.
When annual data are submitted	HMO must comply with NCQA HEDIS submission dates for Medicare enrollees and submit data at the end of June.	HMO must follow NCQA HEDIS submission dates for commercial enrollees and submit data in mid-June.
Satisfaction survey measures for current enrollees	HMO, if it meets CMS's participation criteria, must participate in the Medicare Managed Care Consumer Assessment of Health Plans (CAHPS) survey.[q] CMS administers the Medicare Managed Care CAHPS survey each fall to a sample of HMO's enrollees.	HMO must contract with an NCQA-certified vendor to field the CAHPS 2.0H adult commercial survey. HMO must submit member-level and summary-level data files to OPM by mid-June. Prior to OPM's mid-June due date, HMO must submit member-level data files to NCQA for validation and calculation of summary-level results.
Who participates	HMO that had a Medicare contract in place on or before July 1 of the previous year, including an HMO terminating as of the next contract year.	HMO with at least 500 FEHBP enrollees as of March 31 of the previous year.
Who is sampled	CMS randomly surveys 600 of the HMO's enrollees, not living in an institution, who have been enrolled continuously for at least 6 months, as of July 1 prior to the administration of the survey. If HMO has fewer than 600 eligible enrollees then CMS surveys all enrollees.	HMO must follow NCQA sampling protocols for commercial enrollees.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	JCAHO does not audit data submitted for ORYX measures.	HMO must contract with an NCQA-certified HEDIS compliance audit organization. All of the HEDIS measures that are scored as part of the accreditation process must be audited. NCQA publicly releases the benchmarks and thresholds used in scoring HEDIS and standardized member satisfaction survey results for HMOs with commercial, Medicaid, and Medicare enrollees. NCQA releases summary HEDIS results on its Web site for HMOs with Medicaid enrollees. NCQA also makes available for purchase a national database of HEDIS and standardized member satisfaction survey results.
No applicable requirements.	No applicable standards.	HMO or purchaser.
No applicable requirements.	HMO must submit data on ORYX measures in conjunction with an on-site triennial accreditation survey. Submission does not occur annually.	HMO must comply with NCQA HEDIS submission dates for Medicare enrollees and submit data at the end of June. HMO with commercial or Medicaid enrollees must also follow NCQA HEDIS submission dates and submit data in mid-June.
HMO must collect and analyze information specific to its enrollees, including documentation of enrollee satisfaction.	HMO must continuously and systematically measure enrollee expectations of and satisfaction with care and services provided. HMO must regularly measure, assess, and use information about enrollee needs and satisfaction to improve member services (not necessarily annually). HMO must determine the appropriate detail and frequency of data collection.	HMO with Medicare enrollees must participate in the Medicare Member CAHPS survey administered by CMS; results are from the previous fall. HMO with commercial or Medicaid enrollees must contract with an NCQA-certified vendor to conduct the CAHPS 2.0H adult survey and report the results of the entire survey to NCQA by mid-June. HMO with commercial or Medicaid enrollees must have membership files used to generate survey sample audited as part of the HEDIS compliance audit.
No applicable requirements.	No applicable standards.	HMO with Medicare enrollees has same requirements as M+C.
No applicable requirements.	No applicable standards.	HMO with Medicare enrollees has same requirements as M+C. CAHPS 2.0H sample size for HMOs with adult, commercial enrollees is 1,500 and 1,050 for adult Medicaid enrollees. These sample sizes are changing to 950 and 1,275, respectively, for HEDIS 2002.

(Continued From Previous Page)

Topic	M+C requirements	FEHBP requirements
Who pays for survey administration	CMS.	HMO must pay for an NCQA-certified vendor to field the survey to its enrollees. In addition, HMO must pay a pro rata share of OPM's vendor's total cost of compiling, processing, and reporting CAHPS 2.0H survey data to OPM.
Satisfaction survey measures for disenrollees	HMO, if it meets CMS's participation criteria, must participate in the annual Medicare CAHPS Disenrollment-Assessment survey administered each fall and the quarterly Medicare CAHPS Disenrollment-Reasons survey, administered on an ongoing basis.[r]	No applicable requirements.
Who participates	HMO must participate in the annual Medicare CAHPS Disenrollment-Assessment survey if it had a Medicare contract in place on or before July 1 of the previous year. HMO must participate in the quarterly Medicare CAHPS Disenrollment-Reasons survey if it had a Medicare contract in place on or before January 1 of the previous year. Certain M+C plans, such as demonstrations, are excluded.	No applicable requirements.
Who is sampled	CMS samples Medicare beneficiaries voluntarily leaving for both surveys.[s] For the CAHPS Disenrollment-Assessment survey, CMS surveys Medicare beneficiaries voluntarily leaving their HMO in May, June, or July and who were enrolled for at least 6 months prior to disenrolling. The sample size varies by HMO but is no higher than 600 and is proportionate to the HMO's disenrollment rate. For the CAHPS Disenrollment-Reasons survey, CMS attempts to survey 388 enrollees for each HMO over the four calendar quarters. For this survey, CMS does not have a requirement for length of enrollment.	No applicable requirements.
Who pays for survey administration	CMS pays for both the quarterly and annual surveys.	No applicable requirements.
Health status survey measures	HMO, if eligible, must participate in the Medicare Health Outcomes Survey (HOS).[t] HMO must contract with an NCQA-certified vendor to field the survey.	No applicable requirements.
Who participates	HMO must participate if it had a Medicare contract in effect on or before January 1 of the measurement year.	No applicable requirements.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	No applicable standards.	CMS pays for survey of an HMO's Medicare enrollees. HMO must pay for an NCQA-certified vendor to field the survey to its commercial enrollees. Some states pay for survey of Medicaid enrollees, while others require the HMO to pay.
No applicable requirements.	No applicable standards.	No applicable standards.
No applicable requirements.	No applicable standards.	No applicable standards.
No applicable requirements.	No applicable standards.	No applicable standards.
No applicable requirements.	No applicable standards.	No applicable standards.
HMO must include health status measures in its QI activities related to evaluating courses of treatment and outcomes of health care.	HMO must collect data to monitor outcomes related to prevention, physiological function, functional status, and physical and psychological comfort of enrollees. HMO must determine the appropriate detail and frequency of data collection.	HMO with Medicare enrollees must participate in HOS.
No applicable requirements.	No applicable standards.	HMO with Medicare enrollees has same requirements as M+C.

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Topic	M+C requirements	FEHBP requirements
Who is sampled	Each spring, HMO must survey 1,000 randomly sampled Medicare enrollees who have been continuously enrolled for at least 6 months prior to the survey administration. HMO must also survey again the enrollees who were surveyed 2 years earlier. HOS results are submitted by the NCQA-certified vendors to NCQA, CMS's contractor for administering HOS. CMS performs analysis and also provides reports back to the HMOs.	No applicable requirements.
Who pays for survey administration	HMO pays for the administration of the HOS survey.	No applicable requirements.

[a]HMO must use CMS's Quality Improvement System for Managed Care (QISMC) standards and guidelines to meet the requirements of Part 422, Subpart D, Quality Assurance, of Title 42 of the Code of Federal Regulations. Since January 1998, CMS has released three versions of QISMC, with the most current version issued as of July 26, 2000. OMB has approved the July 26, 2000, version of QISMC through July 31, 2002. CMS is in the process of incorporating the QISMC standards and guidelines into the chapters of the *Medicare Managed Care Manual*; once this is accomplished, QISMC as a stand-alone document will cease to exist for Medicare.

[b]NAIC uses the phrase QI activities rather than QI projects.

[c]JCAHO uses the phrase performance improvement activities rather than performance improvement projects.

[d]HEDIS is a set of standardized performance measures sponsored by NCQA. Since 1992, NCQA has collaborated with managed care organizations, academic researchers, corporate purchasers, and consumer representatives to create HEDIS. HEDIS includes measures that address effectiveness of care, accessibility and availability of care, satisfaction with the experience of care received, cost of care, health plan stability, informed health care choices, use of services, and health plan descriptive information.

[e]In 2002, CMS eliminated the requirement that an HMO annually initiate a multiyear QAPI project on a topic the HMO selected.

[f]CMS contracts with QIOs, who are responsible for promoting effective, efficient, and economical delivery of quality health care services to Medicare beneficiaries.

[g]National topics chosen by CMS include: diabetes (1999), community-acquired pneumonia (2000), congestive heart failure (2001), breast cancer screening (2002), clinical health care disparities (CHCD) or culturally and linguistically appropriate services (CLAS) (2003), and diabetes (2004). CMS originally informed HMOs that the 2002 national QAPI projects would be CHCD or CLAS, but postponed these projects until 2003 based on industry feedback. CMS has contracted for two CLAS projects to produce case studies that HMOs may replicate if they choose to do so.

[h]CMS defines seven clinical focus areas, such as primary, secondary, or tertiary prevention of acute conditions, high-volume services, and high-risk services, and two nonclinical areas, such as availability, accessibility, and cultural competency of services.

NAIC model requirements	JCAHO accreditation standards	NCQA accreditation standards
No applicable requirements.	No applicable standards.	HMO with Medicare enrollees has same requirements as M+C. NCQA certifies survey vendors to administer HOS. HOS data are provided to NCQA by each survey vendor.
No applicable requirements.	No applicable standards.	HMO with Medicare enrollees has same requirements as M+C.

[i]NCQA also requires HMOs to adopt or establish quantitative measures to assess their performance and to identify and prioritize areas for improvement for three clinical areas, including at least one behavioral health measure. However, NCQA does not currently require an HMO to demonstrate a meaningful performance improvement for the behavioral health topic being measured.

[j]CMS has not established or required minimum performance levels or benchmarks for standardized quality measures for any of the national QAPI projects. However, CMS is exempting HMOs that achieved a breast cancer screening rate of 80 percent or better using HEDIS 2001 or 2002 measure specifications from participating in the 2002 national QAPI project on breast cancer screening. Based on HEDIS 2001 Medicare results, CMS exempted 39 HMOs.

[k]Beginning in January 2002, HMO can fill out and electronically submit its Project Completion Report through a Web-based CMS data system.

[l]CMS regional offices evaluate the overall administration of an HMO's QAPI program and health information systems, but not the QAPI projects.

[m]CMS has not required any HMO to conduct a CMS-directed special project.

[n]NAIC stated that the insurance commissioner may be able to take action against an HMO not meeting applicable requirements under the general authority to regulate HMOs, although, in some states, the authority to regulate HMOs is done by another state agency or the insurance commissioner shares oversight with another state agency, usually the Department of Health.

[o]CMS excludes two HEDIS measures—Practitioner Compensation and Arrangements with Public Health, Educational and Social Service Organizations. The Medicare Health Outcomes Survey is included as a HEDIS measure; we excluded the Medicare Health Outcomes Survey in reporting the 23 Medicare HEDIS measures as the survey is discussed separately in this table.

[p]NCQA defines two types of HEDIS compliance audits, partial or full. A partial audit occurs when the HMO, state regulator, or purchaser selects the HEDIS measures to be audited. A full audit occurs when a HEDIS auditor selects a core set of measures to review and extrapolates the core set findings to all measures reported by the HMO.

[q]CAHPS is a standardized member satisfaction survey.

[r]The CAHPS Disenrollment-Assessment survey collects information on Medicare beneficiaries' experiences with their former HMO, and the CAHPS Disenrollment-Reasons survey collects information on Medicare beneficiaries' motivations for changing coverage.

[s]Medicare beneficiaries voluntarily disenrolling chose to leave their HMO for reasons other than death, termination of Medicare parts or part B, moving out of the service area, or HMO nonrenewals.

[t]The Medicare HOS, part of the HEDIS measurement set, is a longitudinal survey that utilizes the HCFA Short Form-36 (SF-36), an instrument used to collect data on physical and mental functioning and other beneficiary characteristics.

Source: GAO summary of information provided by CMS and OPM, including applicable federal statutes and regulations, operational guidance and other agency materials pertaining to HMOs, and interviews with officials. GAO summary of information provided by NAIC, JCAHO, and NCQA, including NAIC model requirements for HMOs, standards from the current JCAHO and NCQA accreditation manuals for HMOs, and interviews with NAIC, JCAHO, and NCQA officials.

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP - 6 2002

To: Laura A. Dummit
Director, Health Care—Medicare Payment Issues
General Accounting Office

From: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

Subject: General Accounting Office (GAO) Draft Report, "Medicare+Choice: Selected Program Requirements and Other Entities' Standards for HMOs," (GAO-02-905)

Thank you for the opportunity to review and comment on the above-referenced report. The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Medicare beneficiaries continue to have many health options available to them.

In general, we agree with the observations cited in the report. This report has no recommendations or concluding observations. Rather, it summarizes requirements on managed care organizations imposed by two Federal programs, Medicare and the Federal Employees Health Benefits Program, as well as, certain requirements imposed by three non-governmental entities.

Specifically, the tables in the appendices do a good job explaining the differences between CMS and other entities. However, the format fails to completely explain why CMS requirements may be more stringent. The first paragraph on page 14 offers some reasons why the Federal Employees Health Benefit Program (FEHBP) differs from M+C, but more detailed analysis of these differences could bring a more complete picture of how the programs differ. We suggest that GAO discuss a more detailed history of the BBA and the legislative changes made to the program since 1997 in order to provide a more comprehensive view of the CMS role as a regulator subject to Congressional enactments and a mandated payment formula.

Again, thank you for the opportunity to review this report. We look forward to continuing our work with you on this important issue.

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