

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE'S OVERSIGHT OF
MANAGED CARE:
MONITORING PLAN PERFORMANCE**



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EXECUTIVE SUMMARY

PURPOSE

To assess how the Health Care Financing Administration is responding to the need for effective oversight of the growing number of managed care plans that have Medicare contracts.

BACKGROUND

The scope and speed of growth in Medicare managed care places stress on traditional tools for oversight. As of February, 1998, 439 plans counted over 6 million beneficiaries as members, a 90 percent increase since December 1994.

Ideally, managed care's capitated payment leads to innovation in providing cost-effective, high quality health care. However, the economic incentives of operating within a fixed budget may encourage plans to limit access to needed care in the interest of increasing profits. This incentive means that the Health Care Financing Administration (HCFA) has a particular responsibility to ensure that beneficiaries' access to services is protected. The 10 HCFA regional offices carry out direct oversight of managed care plans with a site visit conducted every 2 years.

The HCFA has begun three important initiatives that may yield information useful to oversight of managed care plans: (1) requiring plans to report on measures from the Health Plan Employer Data and Information Set (HEDIS); (2) preparing a national, independently administered, beneficiary satisfaction survey, the Consumer Assessment of Health Plans Study (CAHPS); and (3) opening discussions with national accrediting organizations to assess to what extent HCFA's and these groups' standards overlap, and whether collaboration in oversight would be productive and appropriate for Medicare.

Our review utilizes data from site visits to three HCFA regions, interviews with HCFA staff responsible for oversight of managed care plans in the other seven regions, and representatives of managed care plans and beneficiary advocacy organizations. We also reviewed and analyzed HCFA documents, reports, data and the monitoring guide used to assess managed care plans' performance.

FINDINGS

The HCFA's primary oversight approach--a site visit that relies on a rigid monitoring protocol--has fundamental limitations as a way of overseeing managed care plans' performance.

The monitoring review is not structured to keep pace with the rapidly evolving managed care market. It does not address delegation of administrative and clinical functions, or mergers between health plans.

The review protocol has limited flexibility to focus the monitoring visit.

The 2 year interval between monitoring reviews provides only an intermittent snapshot of a plan's operations.

Overall, HCFA is not taking widespread advantage of available data that could be used for ongoing, systematic oversight of plans.

The HCFA is making only limited use of the information it gathers in these reviews for national program management. The agency does not aggregate the results of the reviews to continuously monitor plan performance, national trends, or variations among regions.

Many regional offices do not routinely track beneficiary inquiries and complaints as a means to identify problematic situations in managed care plans.

The HCFA does not routinely analyze its own data, such as disenrollment rates or number of appeals, to identify trends that raise questions about plan performance.

The HCFA is missing opportunities to capture additional data that could assist the agency in monitoring plans' performance.

The HCFA is not requiring plans to submit basic operational data, such as grievance and appeals data, that could be used to assess the delivery of services to Medicare beneficiaries.

The HCFA does not have a formal system in place for receiving input about managed care concerns from the beneficiary advocacy community. The HCFA provides funding for Insurance Counseling and Assistance programs, but does not require these organizations to report routinely on managed care issues.

RECOMMENDATIONS

We recommend that HCFA revise the processes that it uses to monitor the performance of managed care plans.

The HCFA's oversight processes should pay greater attention to capturing information that reflects plans' performance in the constantly evolving managed care market.

The HCFA's oversight processes should provide greater flexibility to target reviews on the specific characteristics of individual plans.

We recommend that HCFA take better advantage of data that are currently available to the agency as a way of monitoring plan performance on an ongoing basis. Toward that end, we believe that the agency should:

- immediately establish and implement a centralized information system that aggregates the results of plan monitoring reports in electronic format.
- immediately establish and use a system to track beneficiary inquiries and complaints that the agency receives regarding managed care.
- provide monthly reports to regional offices on enrollment, disenrollment, and rapid disenrollment.
- require that the Insurance Counseling and Assistance programs report routinely to central office and to regional offices on managed care issues.
- take full advantage of new data that it is collecting, such as the HEDIS measures and consumer surveys, for oversight purposes.
- require health plans to routinely submit data on appeals and grievances.

COMMENTS ON THE DRAFT REPORT

The Health Care Financing Administration provided comments on the draft report. We provide our response to these comments in italics.

The agency concurs with the intent of our recommendation to revise its monitoring processes. The HCFA indicates a number of actions that it is taking to address the issues that we raise:

- a regional initiative to pay specific attention to ways that managed care organizations delegate such functions as utilization review and medical coverage determinations to their contracted provider networks.
- actions to evaluate health plan mergers and acquisitions.
- revisions in current monitoring process in order to establish better methods for targeting plan performance issues.

We believe that these actions are a positive step forward. We will continue to work with HCFA to monitor implementation, progress, and results.

The HCFA concurs with our second recommendation to make better use of available data. The agency cites a number of activities in this regard. *These developments are encouraging; however, we also wish to reiterate some concerns we have:*

- a Health Plan Monitoring System for aggregating and reporting information from monitoring reviews. *We encourage HCFA to use these data for ongoing analysis of plan performance, not just for scheduling reviews.*

- “Medicare Compare,” a health plan comparison chart on HCFA’s home page. *As yet, Medicare Compare is limited to a comparison of plan coverage, benefits, and premiums. It does not include data on performance or quality. We also urge HCFA to be more proactive and include information on appeals and grievances in Medicare Compare.*

- a new system to track beneficiary inquiries and complaints. *In our draft report, we had recommended that the agency establish and use regional systems to perform this task. Because, as the agency notes, a single system should increase data comparability among the regions, we have revised our recommendation to reflect that approach.*

We also added explanatory text in response to technical comments that the agency provided.

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INTRODUCTION

PURPOSE

To assess how the Health Care Financing Administration is responding to the need for effective oversight of the growing number of managed care plans with Medicare contracts.

BACKGROUND

Growth of Medicare Managed Care

As of February 1, 1998, 6 million Medicare beneficiaries--14 percent of the total--were enrolled in 439 managed care plans that participate in Medicare, up from 3.1 million in 244 plans in December 1994. Medicare paid almost \$26 Billion to managed care plans for fiscal year 1997, up from \$19 Billion for all of fiscal year 1996. By all indications, this rate of growth will continue. Thirty one plans are seeking initial approval for Medicare contracts, and 29 plans are seeking to expand their service areas.

Not only has the overall scope of Medicare managed care grown, but expansion has occurred in new areas of the country. For many years, the Western States were the bastion of managed care, both generally and within the Medicare program. Now all regions of the nation are experiencing rapid growth in Medicare managed care plans.

In addition, Medicare managed care plans increasingly are evolving from staff models to more loosely organized provider networks, such as independent practice associations (IPAs). Since December 1994, the number of IPAs type plans grew by 70 percent from 133 to 228 plans in August 1997, and group model plans increased by 40 percent from 79 to 111. In contrast, staff model plans grew from 29 to 31 plans.¹

New Challenges to HCFA Oversight

The scope and speed of these changes place stress on HCFA's traditional tools for performing oversight. The sheer increase in the number and complexity of plans will continue to put even more pressure on staff and budget resources. Staff will need to acquire skills and knowledge that enable them to assess new types of health care delivery systems with different economic incentives. They will need to remain closely attuned to local health care markets.

In Medicare's traditional fee-for-service program, health care providers deliver services and receive reimbursement for each specific service. Managed care introduces a fundamental shift from the fee-for-service program in which delivery and finance are separate activities. Managed care plans receive monthly capitated payments with which they manage both delivery and financing of services.

Medicare supports two primary types of managed care plans, defined by the method under which

the plans are paid. *Risk plans* are paid a monthly per capita premium set at 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. As of August 1997, 88 percent of Medicare beneficiaries in managed care were in risk plans. These plans made up 292 of the 398 managed care plans participating in Medicare. *Cost plans* are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Beneficiaries in cost plans may also obtain Medicare-covered services outside the plan without limitation.²

Ideally, capitation leads to innovation in providing cost-effective, high quality health care. However, the economic incentives of operating within a fixed budget may encourage plans to limit access to needed care in the interest of increasing profits. This economic incentive to limit care means that HCFA has a particular responsibility to beneficiaries to ensure that their ability to access services is protected in the managed care environment. Yet compared with the fee-for-service sector, the agency receives only limited data from managed care plans. As a consequence, HCFA may have difficulty in assessing the extent to which plans limit access to and utilization of services. For example, HCFA receives beneficiary-level encounter and utilization data and profiles of individual provider practices under the fee-for-service system; these data are not made available to HCFA in the managed care system.

THE HCFA's Current Approach to Monitoring Managed Care

The HCFA is responsible for ensuring quality of and access to care provided to Medicare beneficiaries and for safeguarding the program from fraud and abuse. Within 6 to 9 months after HCFA awards a contract to a health plan, staff from the HCFA regional offices conduct an initial site visit to assess the plan's progress. Subsequent on-site reviews are performed every 2 years, unless some type of serious problem is identified or suspected in the interim.

The staff use a standard contractor performance monitoring protocol that addresses Federal statutory and regulatory requirements in 15 areas. The areas examined include how well the plan processes beneficiary enrollments and disenrollments, the plan's structure for quality assurance, how the plan processes grievances and appeals, and the plan's marketing practices. If HCFA determines that a health plan is out of compliance with requirements in any area, the plan must develop a corrective action plan (CAP), which the regional office must approve. The CAP describes actions the plan will take to come into compliance with Federal standards.

THE HCFA Reorganization

Until recently, HCFA's Office of Managed Care (OMC) had central responsibility for guidance of the agency's managed care program. The 10 HCFA regional offices carry out direct oversight of managed care plans, with support from the central office. (Our companion report *Medicare's Oversight of Managed Care: Implications for Regional Staffing*, OEI-01-96-00191, addresses how HCFA's regional offices are staffing for oversight as the number of plans grows.)

Effective July 1997, HCFA reorganized its internal structure. Under the new organizational

structure, managed care functions are part of the new Center for Health Plans and Providers. This reorganization may well affect how the managed care program is administered in the central office and in the regions.

Recent HCFA Initiatives

The HCFA has recently undertaken three important initiatives that, in the long run, may provide information useful to oversight of managed care plans.

- ***HEDIS*** Effective January 1, 1997, HCFA requires health plans to report on performance measures from the Health Plan Employer Data and Information Set (HEDIS) relevant to the managed care population. These measures include a functional status assessment for seniors, intended to provide longitudinal data on plan-specific outcome measures. The HCFA intends to use these measures to help beneficiaries choose among health plans, identify quality improvement opportunities, and identify areas that warrant further review and scrutiny.
- ***CAHPS*** Effective January 1, 1997, HCFA requires health plans to participate in a national, independently administered, Medicare beneficiary satisfaction survey, the Consumer Assessment of Health Plans Study (CAHPS). The HCFA plans to publish results of this survey to help beneficiaries select among health plans.
- ***Enhanced Review*** The HCFA has initiated discussions with three national organizations that accredit health plans--the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC). The goal of this effort is to assess whether, to what extent, and in what areas HCFA's standards overlap with these groups' standards, and to determine whether collaboration in oversight practices would be productive and appropriate for Medicare.

METHODOLOGY

We utilized four sources of data in this inspection.

First, we gathered extensive information from site visits to three HCFA regions: Region 6 (Dallas), Region 9 (San Francisco), and Region 10 (Seattle). During these visits we conducted structured interviews with staff in the regional offices, and with representatives of beneficiary advocacy organizations, managed care plans, and State governments. Our visits included a review of internal HCFA documents and reports from these regions.

Second, we conducted structured telephone interviews with staff responsible for managed care oversight in the other seven HCFA regional offices. We also interviewed staff from the HCFA Office of Managed Care in Baltimore.

Third, we gathered additional information on the managed care oversight process through

structured telephone interviews with representatives of beneficiary advocacy groups and managed care plans. In total, we interviewed individuals associated with 11 managed care plans and 13 beneficiary advocacy organizations.

Fourth, we reviewed and analyzed HCFA documents, reports, and data, as well as the contractor monitoring guide that the agency uses to assess the performance of Medicare managed care plans.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

THE HCFA'S PRIMARY OVERSIGHT APPROACH--A SITE VISIT THAT RELIES ON A RIGID MONITORING PROTOCOL--HAS FUNDAMENTAL LIMITATIONS AS A WAY OF OVERSEEING MANAGED CARE PLANS' PERFORMANCE.

- **The monitoring review is not structured to keep pace with the rapidly evolving managed care market.**

The rapidly changing managed care environment is placing stress on the traditional monitoring approach. The monitoring review addresses issues pertinent to these changes only in marginal ways, an omission that staff we interviewed saw as a serious shortcoming. One staff member who has been working in this area for several years summarized this concern when he told us, "The industry is developing faster than we can keep up."

Two significant types of changes are occurring in the managed care market that make addressing these issues critical. First, the increase in network model delivery systems is often accompanied by a delegation to medical groups of administrative functions, as well as delivery of health services. Delegated functions may include quality assurance, utilization review, and claims review and payment. The monitoring review does not address the nature or implications of these arrangements, such as the adequacy of training for contracted medical groups, how contracts are priced, what the contracts cover, or how the plan pays claims. For example, staff in the regions identified a need to review cases from delegated providers during their review, or to evaluate how delegated quality assurance standards are enforced by the plan. In theory, the plan itself is accountable for all functions, whether delegated or carried out by the plan itself. The protocol, however, does not lend itself to this type of a review.

A second managed care trend is the spate of mergers and affiliations. The implications for HCFA's oversight are unclear, but the agency has little input into decisions about mergers. The issues that these mergers raise are important. One staff member summarized the difficulties in dealing with a pending merger as follows: "We are dealing with two separate organizations, with three risk contracts, that are now trying to merge. There are corrective action plans in place for each of the plans, each CAP in different areas. Their goal is to be a regional delivery system--but how should our office address this merger and the problems in each plan? Which entity do we examine for claims processing, which one for appeals? How do we have one plan with existing problems take over management for the others?"

- **The review protocol has limited flexibility to focus the monitoring visit.**

The on-site review relies on a broad brush, one-size-fits-all protocol that is the same for all managed care plans. The protocol does not differentiate between staff model, network model, or group model plans. In fact, regional staff told us that the protocol is based on the staff model HMO, even though that model comprises fewer than 10 percent of managed care plans with Medicare contracts. The review does not differentiate between plans paid on a risk basis versus those paid on a cost basis, despite fundamental differences in the financial incentives of the two

payment mechanisms.³ In addition, the review is the same for small plans as for large plans, and the same for plans that have been operating for many years as for new plans.

HCFA regional staff consistently told us that the protocol's breadth makes it difficult to complete the review during the time allotted for visits to plans. Case reviews, examination of documents, and interviews with staff and practitioners consume the full three-to-four days that they spend on site. It is apparent that the staff often must make decisions about prioritizing what aspects of a plan's operation they examine. Our concern is that these decisions may be made without a great deal of explicit guidance. Regions report that they use the protocol as a framework for further inquiry into specific areas. Staff in several regions told us that they look at available data about a plan's operations prior to a site visit. However, the information available varies across regions and across plans; it often is not maintained in a systematic format that allows for meaningful analysis and identification of problem areas.

During our field work, we identified three primary concerns about focusing reviews more narrowly. First, because there are no ongoing performance indicators, staff expressed some discomfort about a more targeted review. These staff raised concerns that less comprehensive reviews might miss problems in plan performance. They cautioned that analyzing additional data, such as results from NCQA certification reviews or plan internal management reports, would be needed to identify areas of potential concern to focus on while on site.

Second, site visits to plans comprise a major use of regional office resources. Extending the visit or conducting additional visits is unappealing from a budgetary point of view. Conversely, more targeted visits could allay this concern, by making more effective use of the time actually spent on site.

Third, the growth in Medicare managed care plans has arrived only recently in many HCFA regions. However, many of the staff involved in monitoring managed care plans are new to this field. Learning how to identify and focus on specific problems may require a knowledge base and comfort level that will come only with time, training, and experience.

Staff in one region provided us with an example of how they use data to target their review, which is illustrative of the role that this information can play. In an ongoing review of member disenrollment data, they found one plan with a very high rapid disenrollment rate. This finding led the office to focus an on-site review on the plan's sales practices and incentives. They reviewed in detail the plan's oversight of its sales representatives, how the sales representatives were paid (*e.g.*, percentage of compensation based on commission versus salary), the plan's records on number of disenrollees by sales representative, and information from personnel files, such as progressive disciplinary actions for sales representatives. As a result of this review, the staff was able to uncover problems with the plan's marketing practices and require it to take corrective action.

- **The 2 year interval between monitoring reviews provides only an intermittent snapshot of a plan's operations.**

Staff in HCFA regional offices and representatives of managed care plans agreed that an on-site presence is a critical element of effective monitoring. From our discussions with HCFA and plan officials, we identified three key reasons for conducting site visits. First, the visits require direct examination of beneficiary case records, plan documents, and files. Second, the visits provide an opportunity for face-to-face interaction with plan staff and practitioners, including a formal opportunity for HCFA staff to respond to questions and concerns that the plan may have. Third, staff told us that site visits provide an important sentinel effect on plans, reaffirming the importance of complying with Medicare regulations.

We identified three limitations with the 2 year interval between visits. First, as part of their review, HCFA staff examine a sample of beneficiary cases to assess how well the plan complies with Medicare requirements such as notifying beneficiaries of appeal rights, and how quickly and accurately the plan enrolls and disenrolls members. The review, however, selects cases only from the most recent 6 months. The case review misses the first 18 months of activity following the previous visit. Second, Medicare renews its contracts with plans annually, meaning that at least one renewal will have taken place without an in-depth review of plan operations.⁴ Third, the plan itself may have changed significantly since the renewal. For example, we examined enrollment data for 127 plans operating in December 1994 and December 1996. We found an overall growth in these plans of 73 percent in that 2 year period. Among 92 plans with at least 1,000 members in December 1994, two plans had 10-fold increases in their membership over that period, and 37 plans at least doubled their enrollment.

To be sure, HCFA regional office staff do have ongoing contact with the plans between the biennial site visits. This contact includes interacting with plans to answer beneficiary inquiries and reviewing plan marketing and sales materials. As a result, staff have a sense and a general subjective impression about plan operations. However, the biennial site visit remains the only formal mechanism through which HCFA assesses plan compliance with Medicare requirements.

OVERALL, HCFA IS NOT TAKING WIDESPREAD ADVANTAGE OF AVAILABLE DATA THAT COULD BE USED FOR ONGOING, SYSTEMATIC OVERSIGHT OF PLANS.

- **The HCFA is making only limited use of the information it gathers in the on-site reviews for national program management.**

Following each review, regional office staff prepare a report that describes their findings and specifies areas in which the plan did not meet Medicare requirements. The regional office sends this report to the plan and to the HCFA central office.

Staff from both regional and central offices told us that these reports are filed away after only limited review of the contents. The agency does not aggregate the results of the reviews in a way that could provide benchmarks on individual plan performance, national trends, or variation among regions.

Only four regional offices were able to provide us with aggregate information on reviews conducted in 1995 and 1996. We reviewed these data, based on 76 monitoring visits to managed

care plans, to provide examples of how HCFA could use data from these reviews to identify issues that warrant further investigation.

First, the information can inform HCFA nationally about areas in which plans need to improve their understanding of Medicare requirements. The HCFA can then use this information to identify specific substantive Medicare requirements that plans fail to meet consistently. The agency could then develop a technical assistance effort to bring plans into compliance. For example, we found that between 60 and 84 percent of the plans in each of the four regions did not meet Medicare requirements for processing beneficiary appeals, considered one of the key consumer beneficiary protection mechanisms in the program. The failure of so many plans to comply with these provisions strongly suggests that HCFA needs to address appeals processing in a conscientious manner to ensure that plans are complying with these requirements.⁵

Second, information from these reviews can help the agency assess how well its protocol is working, and where improvements might be made. For example, we found that only 8 percent or fewer of plans did not meet Medicare standards for utilization management. Examining these data nationally could lead HCFA to question (a) whether the protocol element does not adequately address utilization management; (b) whether regional office staff do not know how to probe into issues concerning utilization management; or (c) whether it is even necessary to review utilization management on a routine basis, because virtually all plans meet the requirement.

Third, nationally aggregated data would help HCFA identify regional variation among its own offices, as a way of identifying regions in which technical assistance is warranted. We found substantial variation among the four regions. For example, one regional office found no plans out of compliance with grievance processes; another office found 53 percent of plans out of compliance. Although one explanation could be regional variation in the actual performance of plans, there is also the very real possibility that the knowledge and skill levels of the different regional office staff vary substantially in their ability to identify this deficiency.

- **Many regional offices do not routinely track beneficiary inquiries and complaints as a means to identify problematic situations in managed care plans.**

Responding to beneficiary inquiries about managed care comprises a major activity of regional office staff. These inquiries include general questions about managed care and how it relates to fee-for-service Medicare, as well as specific complaints about the services provided or denied by a particular plan, and confusion with plan policies, provider networks, service areas, and other nuances of managed care.

Staff in one region summarized the significance of this interaction when they told us, "The most important piece of monitoring is the beneficiary calling us." The volume of inquiries is quite large. Staff in one region told us that they spend between 30 and 50 percent of their time on inquiries. In another region, staff estimated an average workload of more than 100 inquiries each week, and a third region told us that they received over 2,200 inquiries in 1996. Some regional managed care offices maintain a full-time staff unit dedicated to beneficiary case work.

The HCFA developed the Beneficiary Inquiry Tracking System (BITS) some years ago, yet only four regions are using it. Despite the value and number of beneficiary inquiries, many regional offices do not track this information according to specific issues raised or particular plans cited. Regional offices' primary complaint about BITS is the cumbersome nature of the system. The BITS does not interact with other HCFA systems and, as a result, is very slow and time consuming. One staff member (whose office had abandoned BITS) estimates that it takes 2 to 5 minutes simply to access the system and enter a complaint.

Our concern is that the other six regions lack an alternative method to systematically keep track of and trend the types of inquiries that they receive according to issue and plan. Tracking beneficiary concerns in a systematic and ongoing way could inform HCFA about managed care plans' policies, programs, or other issues that the agency may need to address. Plan-specific information could inform the staff about particular concerns in a plan that the monitoring process should address.

The staff from one regional office that uses BITS provided examples of its usefulness. They cited a comparison of two plans, each with approximately the same numbers of beneficiary inquiries, even though one plan was three times the size of the other. In other words, the rate of inquiries was three times as great in the smaller plan, leading the staff to keep a closer watch on that plan.

- **The HCFA does not routinely analyze its own data, such as disenrollment rates or number of appeals to identify trends that raise questions about plan performance.**

Data collected by HCFA on enrollment, disenrollment, and appeals are not in themselves sufficient to make determinations about a particular plan's performance. These data can, however, serve as part of an early warning system, and provide information which the regional staff can use to raise questions about and probe deeper into a plan's performance. For example, we previously found that disenrollment rates, adjusted for annualization of new HMOs and administrative disenrollments, can provide an early alert of problems among Medicare risk HMOs.⁶ Rapid disenrollment patterns may be an even more striking indicator of dissatisfaction, *i.e.*, those beneficiaries who disenroll early in their membership in a plan.

We identified three primary constraints on making effective use of these data for monitoring purposes: First, it is up to the regions to analyze and use these data. We found that a number of the regional offices lack the capacity to carry out these functions.⁷ Even where the regions are comfortable with analyzing data, we found different definitions, particularly in the area of rapid disenrollment across the regions. In one region, the denominator was the entire membership population of the HMO; in other regions the denominator was only those who had enrolled in the previous 3 months. Using the former definition, one is given the impression of a much lower rapid disenrollment rate than the latter definition provides.

Second, regional staff raised concerns about the incompatibility of the HCFA mainframe computer systems and regional offices' personal computers and windows-based applications. This problem is evident in the region's reluctance to use the BITS system. It also affects how regions access and use data from other HCFA data systems, such as the Managed Care Option Information (MCCOY)

System, without reentering the data themselves, or without having direct access to these data. To be sure, the Medicare Transaction System holds promise for improving this situation, but its deployment is far off and yet to be tested.

Third, the staff raised concerns about the adequacy of data the regional offices receive from the Center for Health Dispute Resolution (CHDR), HCFA's contractor that makes final determinations on appeals. These staff reported that they receive detailed information only on those appeals decisions that are decided in favor of the beneficiaries. They also receive aggregate data on rates of appeals and rates of appeals ruled in favor of the beneficiary. Staff told us that they would find additional data useful for oversight purposes. These data could include:

- ▶ Timeliness of plans' reconsideration submissions.
- ▶ Specific cases that have been pending longer than 60 days.
- ▶ Specific issues involved (*e.g.*, are they all emergency visits? Who makes the denial decision?).

THE HCFA IS MISSING OPPORTUNITIES TO CAPTURE ADDITIONAL DATA THAT COULD ASSIST THE AGENCY IN MONITORING PLANS' PERFORMANCE.

- **The HCFA is not requiring plans to submit basic operational data, such as grievance and appeals data, that could be used to assess the delivery of services to Medicare beneficiaries.**

Regional office staff with whom we spoke expressed frustration at not having more data available from managed care plans on a routine basis. If a plan's operation deteriorates after a review is completed, there is no guarantee the regional office will become aware of it before the next review. The HCFA has begun to require submission of HEDIS and CAHPS data, beginning in 1997, and the agency plans to publish summaries of this information as a way of helping beneficiaries choose among health plans. When these data become available, HCFA staff could use them for ongoing oversight of plan operations.

Determining whether or not to require additional data from plans, and what elements to include, would be up to HCFA nationally. In at least one region, the office is working with plans to submit quarterly data in an electronic format. However, staff elsewhere told us that requests for operational data from plans would need to be made an explicit condition of their contract with Medicare in order to avoid resistance by plans.

Managed care plans maintain sophisticated management systems to track information on a wide range of indicators, including beneficiary complaints, claims data, information on the provider network, and utilization data that could be useful to HCFA for oversight purposes. Staff from plans told us that they view contact with HCFA around these types of data as a chance to learn and correct problems as they occur rather than after months of mistakes. As staff at one health care plan told us, "It isn't enough for HCFA to receive the data and come out every two years. They

need to give us continuous feedback as a way of improving our practices."

Staff in the regional offices told us that the following types of data would be useful in their ongoing oversight of plan activities:

- ▶ Denials of payment and service: Number of initial denials, number appealed, number resolved internally, timeliness for resolution, issues involved in cases.
 - ▶ Grievances: Number of grievances, timeliness of resolution, issues involved.
 - ▶ Changes in provider networks: Monthly updates of physicians, hospitals, medical groups and other providers who have joined or left the network.
 - ▶ Contract data: Number of contracted providers, types of arrangements.
 - ▶ Internal customer service data: Number of inquiries, telephone response rates and times, issues raised.
 - ▶ Provider claims processing: Timeliness, denial rates.
- **The HCFA does not have a formal system in place for receiving input about managed care concerns from the beneficiary advocacy community.**

The HCFA funds beneficiary outreach services through grants to Insurance Counseling and Assistance (ICA) programs. The ICAs report to HCFA twice per year with a broad overview of their activities and use of HCFA funds. However, these groups do not report in a formal routine way to the regional offices on beneficiary concerns related to managed care or the performance of specific managed care plans.

The ICAs work directly with individual beneficiaries to resolve problems that they encounter in obtaining Medicare services. Staff of the ICA programs with whom we met reported that they are receiving greater numbers of beneficiary concerns around managed care. One group estimated that 40 to 50 percent of their work involved managed care. The ICAs work to resolve beneficiary problems by working on a case-by-case basis with health care providers.

The ICAs typically are part of a State Office on Aging or State Insurance Department. Regional offices work with the ICAs in two primary ways. First, an ICA may contact staff in the regional office to help resolve a beneficiary's specific case or problem with a managed care plan. Sometimes the regional staff may intervene with a plan as part of this resolution.

Second, regional office care staff reported that they try to speak at ICA meetings to discuss Medicare managed care and to address concerns that may have been raised. One important component of this outreach is to ensure that beneficiaries and the ICA volunteers and staff are aware of beneficiaries' rights under managed care.

RECOMMENDATIONS

In this report we raise fundamental concerns with HCFA's primary approach to oversight of Medicare managed care plans. That approach revolves around one formal site visit conducted every two years. We raise concerns about the efficiency and adequacy of this approach as a way of monitoring plan performance in a rapidly changing environment. Medicare contracts with an expanding number of plans, beneficiaries continue to enroll at a rapid rate, and the managed care markets and the structure of plans themselves are constantly evolving. Yet, the current approach has no formal mechanisms to keep up with plan activities between reviews, nor is it sufficiently flexible to respond to the changes in the market place or even to the characteristics of specific plans and the differences among them.

We recognize that HCFA is taking a number of steps that could enhance oversight of managed care plans. For example, the implementation of the HEDIS measures, the new consumer assessment of health plans, and the agency's work with national accrediting bodies provide major opportunities to improve oversight of managed care plans. At the same time, however, we conclude that more must be done to afford sufficient protections to Medicare beneficiaries.

Our recommendations focus on two broad themes. One set of recommendations urges the agency to revise the approach that it currently uses to monitor the performance of managed care plans, to make that approach more flexible and responsive to the current reality of the managed care market place. The second set urges HCFA to make better use of data as a key element for ongoing contact and oversight of plan activities. We believe such an approach is essential if the agency is to keep abreast of managed care plans' performance. The demands and challenges of the new Medicare+Choice program make steps such as these even more critical.

We also emphasize that oversight of managed care plans requires staff with the appropriate training and analytical skills. Our companion report, *Implications for Regional Staffing* (OEI-01-96-00191), addresses this issue in detail; in that report we make recommendations regarding HCFA's staffing and training needs.

WE RECOMMEND THAT HCFA REVISE THE PROCESSES THAT IT USES TO MONITOR THE PERFORMANCE OF MANAGED CARE PLANS.

The HCFA's oversight processes should pay greater attention to capturing information that reflects plans' performance in the constantly evolving managed care market.

Many managed care plans rely on widespread network models to deliver services. In network models, the actual delivery of services, decisions regarding coverage, and utilization management may be contracted out to providers at some distance from the managed care plan that bears overall responsibility for providing care to beneficiaries. Yet current monitoring of managed care plans rarely includes review of these widespread entities. We believe that it would be prudent for the agency to include a more in-depth examination of delegated contractors as a formal part of the review process. One option might be to include a review of records from and

interviews with a representative sample of delegated providers in network model plans.

The increasing numbers and scope of mergers and affiliations taking place among managed care plans presents a second challenge for HCFA's oversight processes. We believe that the agency needs to pay attention to where responsibilities lie when plans merge. For example, HCFA may need to assess how problems found in one plan are being corrected when that plan has merged with another company. One option is instituting some type of formal review of Medicare operations in the new entity at an appropriate point following the merger, say 3 or 6 months. In addition, we encourage the agency to be sure that sufficient attention is paid to the implications of mergers and affiliations prior to their actually taking place.

We also are concerned about oversight of new types of organizations providing managed care services. For example, the recently enacted *Balanced Budget Act of 1997* authorizes the participation of provider sponsored organizations (PSOs) in the Medicare program.⁸ The PSOs may be subject to little State regulation or certification, so monitoring these new entities will pose fresh challenges to the agency. We believe that HCFA needs to pay close attention to these and other new arrangements to ensure that they meet requirements for participation in Medicare.

The HCFA's oversight processes should provide greater flexibility to target reviews on the specific characteristics of individual plans.

We believe that HCFA should consider how its oversight function can be enhanced by designing a protocol and approach that take into account key differences among plans. For example, risk plans have a quite different financial arrangement than cost plans, with the potential for adverse economic incentives based on their payment mechanism; yet the monitoring protocol does not differentiate between these types of plans. As we note above, IPAS may bear further inquiry into the specific implications of their organizational arrangements than do group or staff model plans.

We also believe that flexibility may be warranted as a way to assess the progress being made by managed care plans with new contracts. For example, current processes call for the agency to conduct a monitoring visit 6 to 9 months after awarding a contract, to ensure that the new plan understands and is meeting Medicare requirements. Following that initial visit, HCFA staff do not conduct a second monitoring review for another two years. Yet, in many cases plans may not have a large enrollment in the first few months; it may well be appropriate to conduct a follow up visit at the point at which a plan reaches a certain critical mass, for example, 1,000 or 5,000 members.

WE RECOMMEND THAT HCFA TAKE BETTER ADVANTAGE OF DATA THAT ARE CURRENTLY AVAILABLE TO THE AGENCY AS A WAY OF MONITORING PLAN PERFORMANCE ON AN ONGOING BASIS.

In examining data, we suggest four basic types of analyses that HCFA staff could undertake as a way of informing the agency for oversight purposes:

- ▶ Internal trends in plan performance over time. This would let HCFA identify changes

within a plan that may indicate concerns that HCFA should help the plan address.

- ▶ Plan performance compared with regional norms. This comparison will let HCFA determine how plans compare with other plans in the region for which it has oversight responsibility.
- ▶ Performance of plans compared with other plans in the local market area. This provides a more refined comparison, taking analysis to the local market area.
- ▶ Performance of plans compared with national norms. While there may be explainable local differences, HCFA also needs to assess the plans within national norms and expectations.

The HCFA should immediately establish and implement a centralized information system that aggregates the results of plan monitoring reports in electronic format.

Although the monitoring protocol has its limitations, in the short run it remains the primary tool through which HCFA assesses the performance of managed care plans. Consequently, we believe it essential that HCFA have aggregate data on these reports to provide national accountability for the program. In an era of ready access to electronic formatting, there simply is no reason that the information from these reviews should not be made immediately accessible to beneficiaries and the public, to members of Congress, and to agency managers.

We envision a system similar to the On-Line Survey Certification and Reporting System (OSCAR) that yields information on surveys for hospitals, nursing homes, and other institutional providers. We believe that the simplest way to implement such a system would be for regional staff to enter the results of their reviews into a system immediately upon completion of their monitoring visit.

We see four important advantages for such a system. First, it will enable HCFA to readily monitor each plan's performance. Second, it will enable HCFA to identify overall areas of concern in managed care plans' operations. This information can help the agency identify broad problems that need to be addressed nationally. Third, it will inform the agency about regional variations in performance among health plans and among regional offices. Fourth, this information will provide an important starting point for assessing the protocol instrument itself.

The HCFA should immediately establish and use a system to track beneficiary inquiries and complaints that the agency receives regarding managed care.

Several regions already track these data . We believe that it is a key source of information that regional staff should use routinely to identify specific plans or issues that merit closer examination. The system needs to be plan specific and issue specific. We believe that it should be maintained in electronic format so that current issues and trends may be examined, both locally and nationally. The system should include fields for general inquiries about managed care, as well as specific concerns and problems regarding particular plans. The HCFA established the Beneficiary Inquiry Tracking System (BITS) with this as one goal. But that system is slow

and cumbersome. We believe that HCFA needs to use a tracking system that is manageable and easy for regional staff to use. Our goal is to have in place a system to track and analyze this important source of data.

The HCFA should provide monthly reports to regional offices on enrollment, disenrollment, and rapid disenrollment.

In 1995, we recommended that HCFA track disenrollment rates over time to detect potential problems among HMOs and that the agency use adjusted disenrollment rates to target reviews of HMOs.⁹ We continue to believe that this is an important aspect of plan operations that HCFA regional offices should monitor routinely. Many regions are already tracking these data on their own, but we found, among other problems, that there is no standard definition of what constitutes rapid disenrollment. It would be more efficient and accurate for HCFA centrally to provide these data to the regions in a format that permits the regional offices to analyze them over time.

The HCFA should require that information, counseling, and assistance programs report routinely to central office and to regional offices on managed care issues.

The HCFA provides financial support for information, counseling, and assistance programs. We believe that they are an important resource that the agency could tap for additional information about plan performance. The HCFA could provide a reporting format for these grantees on managed care, which should be plan specific and issue area specific.

The HCFA should take full advantage of new data that it is collecting, such as HEDIS and CAHPS, for oversight purposes.

The HCFA is now collecting beneficiary-level data through HEDIS and CAHPS. The agency plans to make plan-specific data from these surveys available to the public as a way to help beneficiaries choose among health plans. These data also can be used as part of a data-driven monitoring system to identify concerns about plan performance.

The HCFA should require health plans to routinely submit data on appeals and grievances.

In 1996, we recommended that HCFA require managed care plans to report data on appeal and grievance cases, including the number of cases; the number resolved internally and externally, and their outcome; issues involved in cases; and time needed to resolve cases.¹⁰ We believe that these recommendations are still appropriate.

COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the Health Care Financing Administration (HCFA). In this section, we address issues that the agency raises in those comments. Below we summarize the major thrust of the agency's comments regarding our recommendations, and we offer our response in italics. We present the full text of HCFA's comments in Appendix A.

Oversight of plans in the constantly evolving managed care market.

The HCFA concurs with the intent of our recommendation.

The agency indicates that its Region IX office (San Francisco) is paying specific attention to ways that managed care organizations delegate responsibilities to provider networks with which they contract. Delegated activities include utilization review, medical coverage determinations, and other activities normally operated by a plan itself. This regional office has developed a process that managed care plans can use to oversee delegated activities. The HCFA notes that it will evaluate the effectiveness of this process. *We urge HCFA to continue close examination of delegated arrangements. We believe that all regional offices need to pay close attention to such arrangements. Should the special monitoring effort underway in Region IX prove effective, the agency may wish to incorporate this approach into its national monitoring protocols.*

The HCFA notes that it evaluates mergers and acquisitions of health plans to assess compliance of new entities with Medicare requirements. The agency sees no reason for a standard review of these transactions at this time. *We are pleased that HCFA is reviewing mergers and acquisitions prior to giving its approval. We continue to believe that the agency should review Medicare operations of these newly formed entities shortly after the merger has taken place, rather than waiting for the full two-year cycle between scheduled monitoring visits.*

The HCFA reports that it is revising its current monitoring processes. The objective is to establish better methods for targeting performance issues within plans and for establishing quality improvement goals. *We believe that these revisions are a positive step forward. We note that the agency is now circulating a draft of a revised monitoring guide. This draft includes, for example, new language addressing review of delegated activities, such as those described above. We also encourage use of performance data to establish improvement goals. We will continue to work with HCFA to assess implementation, progress, and results.*

Making better utilization of available data

The HCFA concurs with our recommendation.

The HCFA cites its development of a Health Plan Monitoring System (HPMS). The agency notes that much of the information gathered under the HPMS will be included in an electronic comparison chart on HCFA's home page. *The development of the HPMS is a positive step, and we urge the agency to move forward as rapidly as possible with implementing this management*

information system. We must note, however, that the Medicare Compare electronic data base is limited to a description and comparison of plan coverage, benefits, and premiums. Although an improvement over previously available information, Medicare Compare does not yet include any plan performance data, nor results from the monitoring review. We recognize that the Medicare Compare data base is in the early stages, Version 1. But more can be done to include quality and performance indicators in that data base.

The HCFA notes that the Balanced Budget Act requires managed care plans to disclose grievance and appeal information when requested by beneficiaries. *We urge the agency to be even more proactive and include this information in the Medicare Compare system. Because managed care plans are required to make this information available to individual beneficiaries, HCFA could also coordinate the release of this information through its public data base.*

The agency reports that it has developed an electronic database for aggregating and reporting information from monitoring reviews. *We are pleased that HCFA has developed such a data base. We believe that it is an essential tool for conducting effective oversight of managed care plans. As described by the agency, such a system can serve two functions: One function is to ensure appropriate scheduling around the review process. Certainly this is an important task in managing the workload associated with monitoring plan performance. The second—and in our view more critical—purpose of such a system is to assess and analyze the ongoing performance of plans. We urge HCFA to ensure that this latter goal of analysis receive attention that is commensurate with, if not greater, than the scheduling uses.*

The HCFA reports that it has developed a new system to track beneficiary inquiries and complaints. *In our draft report, we had recommended that the agency establish and use regional systems to perform this task. Because, as the agency notes, a single system should decrease confusion and lack of comparability among the regions, we are revising our recommendation to reflect that approach. So long as the new tracking system is easy to use for the regional staff—if it avoids the cumbersomeness of the old Beneficiary Inquiry and Tracking System (BITS), it will go a long way towards providing a national capacity and data base.*

We also are encouraged that HCFA will be taking advantage of the HEDIS and CAHPS data as part of its monitoring system. These data will be sure to shed important light on plan performance.

Technical comments

The HCFA provides two technical comments. One comment relates to our concern about the monitoring approach not accounting for differences between risk and cost-based plans. The agency points out that the Balanced Budget Act of 1997 prohibits new cost contracts and requires that existing cost plans may be paid on that basis only through 2002. The second technical comment discusses the requirements of the Balanced Budget Act that phases out the opportunity for beneficiaries to disenroll from plans on a monthly basis, substituting instead a longer lock in period. *We reference these points in notes accompanying the appropriate text. Yet we also believe that until these changes have been actually implemented, both issues we identify are concerns to which the agency should pay some attention.*

APPENDIX A

AGENCY COMMENTS ON THE DRAFT REPORT

This appendix contains the complete set of comments from the Health Care Financing Administration on this report, as well as a companion report, "Medicare's Oversight of Managed Care: Implications for Regional Staffing," (OEI-01-96-00191).



DATE: MAR 11 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *NMD*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Medicare's Oversight of Managed Care--Monitoring Plan Performance, (OEI-01-96-00190) and -- Implications for Regional Staffing, (OEI-01-96-00191)"

We reviewed the above-referenced reports that address the Health Care Financing Administration's (HCFA's) oversight of managed care plans and staffing in the regional managed care units. The reports found that although HCFA has made a strong commitment to increase staffing for managed care oversight, its oversight approach is not structured to keep pace with the rapidly evolving managed care market, and the majority of regional office (RO) staff does not have managed care, data analysis, or clinical backgrounds.

Our approach to improve managed care oversight is aimed at full compliance with the President's *Health Care Consumers' Bill of Rights*. Particularly noteworthy is our development of the Health Plan Monitoring System (HPMS). This system will consolidate data obtained from monitoring reviews including: quality of care; beneficiary satisfaction; enrollment and disenrollment; appeals and grievances; benefits and premiums; and physician incentives, among other areas. Much of the information gathered under HPMS will be included in an electronic consumer comparison chart know as "Medicare Compare" that will be available to beneficiaries, health insurance counselors, and the general public on HCFA's home page. We believe that HPMS, along with other initiatives described below, will improve our current health plan monitoring regime and ensure progress toward full *Bill of Rights* compliance.

HCFA concurs with the intent of all of the OIG recommendations. Our detailed comments are as follows:

OIG Report - "Monitoring Plan Performance." (OEI-01-96-00190)

OIG Recommendation 1

HCFA should revise the processes that it uses to monitor the performance of managed care plans.

HCFA Response

We concur with the intent of the recommendation. HCFA's Region IX has paid specific attention to the delegation of managed care responsibilities that occurs when contracting companies allow provider networks to conduct utilization reviews, make coverage determinations, and operate other activities normally conducted by the health plan itself. This contractor activity has resulted in a monitoring process for contracting companies to use with the provider networks. HCFA will evaluate the effectiveness of the process to determine if it will require a similar approach for all contracting companies who delegate activities.

HCFA evaluates each merger and acquisition to ensure that the new entity complies with requirements for eligibility. HCFA also identifies problems that will affect the operation of any contract following the merger, and will delay its approval of any merger where it is clear that compliance with contracting requirements will be affected by a merger. Under all circumstances, the merged company is always required to meet requirements. Reviews occur on an ad hoc basis and HCFA sees no reason to develop a standard review process at this time. For example, HCFA is currently in the process of determining the effects of the merger between two of HCFA's largest Medicare managed care contractors: FHP, Inc. and Pacificare, who serve over 608,000 Medicare beneficiaries. An extensive site visit was conducted, and corrective actions will be required where applicable. At the same time, a large insurer purchased the assets of a contracting health maintenance organization (HMO) with 8,000 Medicare members to form a merged company with a Medicare line of business. In this case, HCFA reviewed the pro forma financial statements along with the plan for the organization of the merged company. No further evaluation was necessary in this case.

Under the current process, HCFA reviewers use a review guide which stipulates all requirements for contracting health plans. Methods of evaluation contained in the guide dictate the methods that reviewers should use to review each specific requirement. In addition, standard operating procedures define the kinds of reviews that regional reviewers can use to conduct monitoring operations. These are full biennial reviews conducted every 2 years, post contract site visits conducted within the first year of contract operations, and focused reviews conducted at any time to determine compliance

with specific areas of operations. In addition, HCFA conducts formal investigations with contracted consultants whenever there is a need for intensive review of multiple areas due to poor overall performance.

HCFA, however, is revising the current monitoring process. First, HCFA will add new items to the guide, as well as evaluate additional changes to the methods of evaluation. Changes to the methods of evaluation will consider the types of review activities that are required for different types of managed care organizations. Second, HCFA will devise better methods for targeting performance issues within health plans. Third, HCFA will set a direction for use of continuous quality improvement goals with each health plan on a periodic basis. HCFA has obtained the services of a consultant who will provide recommendations on the overall directions of the monitoring program. The new approach will consider the use of performance data to establish goals for health plans on an annual basis so that health plans are required to improve over each year's performance. This approach is similar to the approach used by commercial employer groups to contract only with health plans that are capable of meeting higher goals.

OIG Recommendation 2

HCFA should take better advantage of data that are currently available to the agency as a way of monitoring plan performance on an ongoing basis.

HCFA Response

We concur and are taking steps to ensure that the data collection process and reporting of appeals and grievance information are both meaningful to consumers and fair to plans. HCFA has already received data from Health Plan Employer Data and Information Set (HEDIS) 3.0 and is beginning to analyze them. HCFA is initiating activities to analyze plan-submitted disenrollment rate data. In addition to the Consumer Assessment of Health Plan Survey (CAHPS) mentioned in the Executive Summary, other activities are underway to capture beneficiary disenrollment reason data from the regions, the Social Security Administration, and plans. HCFA is also working to further define the type of data we will need to collect to gain additional information about plan performance.

HCFA is in the process of planning the development of a Health Plan Monitoring System (HPMS). This project will consist of the establishment of a database and the development and deployment of client/server applications to provide HCFA central and regional office staff with access to information in the database for the purpose of plan and program oversight. The HPMS will provide HCFA with access to quality of care measures from HEDIS, financial data, beneficiary appeals information, beneficiary satisfaction data from CAHPS, physician incentive data, and benefits/premium and

member cost sharing data. Some of the information from the HPMS will also be included in a consumer comparison chart which will be made available to the public through the Internet to allow beneficiaries to make informed choices of plans.

Regarding the collection and consistent reporting of accurate appeals and grievance data, HCFA has secured the services of an impartial, independent contractor to reconsider denial determinations and to perform the necessary functions associated with this activity. The contractor's services include data reporting activities such as the ones recommended by OIG. In addition, section 1852(c)(2)(C) of the Balanced Budget Act of 1997 (BBA) requires Medicare+Choice (M+C) plans to disclose the following data upon request by M+C eligible individual: (1) information on the number of grievances, determinations, and appeals, and (2) information on the disposition in the aggregate of such matters. By requiring plans to collect and disclose internal plan-level data, the BBA lays the groundwork for this form of data collection by HCFA.

HCFA has devised an electronic database for aggregating and reporting information obtained from monitoring reviews. This database contains information on the number of monitoring reviews that are conducted, the frequency of the monitoring review, the timeliness of the report of review findings to the health plan, as well as the individual findings. The database can provide reports on a national, regional, or state basis so that the variations in performance and the types of review findings can be reported. In addition, HCFA will learn the most common problems, as well as provide trend data on each plan as review findings are entered.

At the current time, the Regional Office Systems Workgroup operates as a user's group that modifies and provides direct data support to its regional office monitoring reviewers. The group facilitates the use of all available data by sharing programming and software programs that manipulate available data. The group meets monthly via conference calls to address new ideas or questions about data or programming issues for all regions. Depending on their capabilities and needs, individual regions make use of the data reports that are developed by the workgroup for monitoring the health plans in their region.

On a much larger scale, HCFA is establishing the HPMS. This new system will consolidate data obtained from monitoring reviews, enrollment and disenrollment, reconsideration, HEDIS and CAHPS, as well as benefit and premium information. HCFA's goal is to design a system that provides data that are available for monitoring health plan operations. HPMS will also provide reports that will be useful for trend analysis or health plan comparisons. HPMS will identify outliers, as well as provide indicators for HCFA inquiries regarding plan performance.

As noted in the report, not all regions are using the Beneficiary Inquiry Tracking System

(BITS). HCFA believes that it is necessary to establish a single system to track inquiries and complaints. Allowing each region to establish its own system will lead to confusion and a lack of comparability between regions. To this end, HCFA has designed a computer system to receive, track, and report about beneficiary inquiries. As soon as programming is complete and the overall system put in place, HCFA will use this system for tracking Medicare beneficiary inquiries.

HEDIS and CAHPS data will receive significant scrutiny under HPMS. These data will not only become part of the data release to the public in the comparability chart, but will also become a significant part of the monitoring process in terms of identifying outliers and also in terms of setting goals for continuous improvement in health plan performance.

OIG Report - "Implications for Regional Staffing." (OEI-01-96-00191)

OIG Recommendation 1

HCFA should develop, coordinate, and provide a comprehensive training program for regional office staff with responsibility for oversight of managed care plans.

HCFA Response

We concur. HCFA initiated a two-part training program in July 1997. First, HCFA implemented a basic training program which is aimed at new staff. This 5-day program provides a description of basic regulatory requirements, as well as the application and monitoring process and procedures. In addition, the program describes the major components of review for any health plan for either the application or the monitoring reviews. The second part of the training program will include advanced training for persons who have completed the basic program. This specialty training will focus on elements of review for five separate specialty review areas. These are: legal, health services delivery, quality assurance, fiscal soundness and insolvency, and Medicare operations.

HCFA also conducted regular training on new issues during 1997. In the past year, HCFA staff conducted training on point-of-service, visitor affiliate, and flexible benefit products, as well as expedited appeals and the new marketing guidelines. This type of training has occurred not only in individual Picturetel sessions but also during HCFA's annual regional office/central office HMO conference. Training for expedited appeals occurred at five different conferences throughout the nation to accommodate both regional staff and industry personnel.

OIG Recommendation 2

As HCFA increases staff in its managed care operations in the regional offices, we recommend that the agency seek out people with experience in managed care, data analysis, and clinical expertise.

HCFA Response

We concur. HCFA has transitioned a number of staff in the regional offices to managed care activities. Whenever possible, HCFA will identify staff with special analytical skills, as well as clinical and managed care experience. In central office, HCFA's reorganization has brought a significant change in the amount of resources that are currently addressing managed care issues. Previously, the Office of Managed Care with its staff of approximately 150 persons operated the managed care program. With the reorganization of HCFA, the number of persons with responsibility for managed care issues has significantly expanded. For example, data analysis activity has become the major focus of one division. Previously, HCFA had no organized component responsible for ongoing analysis of managed care data. Two other changes include the transfer of quality assurance issues to the Office for Clinical Standards and Quality and the transfer of beneficiary issues to the Center for Beneficiary Services. The latter two changes will bring together individuals with clinical skills for review of managed care quality issues and will bring increased visibility to issues presented to HCFA from advocacy groups who will communicate and coordinate their activities with the Center for Beneficiary Services. The two changes will begin to more readily identify and define quality issues and beneficiary issues for review during the monitoring process. As the components refine their managed care responsibilities, their counterparts in the HCFA regional offices will conduct their operational responsibilities with the health plans in their regions.

OIG Recommendation 3

HCFA should develop a pilot program to provide opportunities for staff development and staff sharing with managed care plans and with beneficiary advocacy groups.

HCFA Response

We concur with the intent of the recommendation. For example, HCFA provided rotational positions for 4 weeks to six persons from the American Association of Health Plans Minority Management Development Program. HCFA subsequently hired four of these persons because of their managed care experience. HCFA makes use of the *Presidential Management Intern Program* in order to place persons in training assignments in the managed care industry. The interns are employed in both the central office, as well as the regional offices. In addition, HCFA has placed other persons in HCFA management training programs in managed care companies for rotational assignments. HCFA will continue to seek opportunities for staff for these types of rotational assignments. The broadening of managed care responsibilities resulting from HCFA's reorganization will allow HCFA staff to identify training opportunities that will provide specific experiences that will complement their skills and knowledge.

HCFA is committed to allowing the rotational assignments to occur whenever possible. However, our concern with the recommendation is that HCFA has information on

currently contracting plans and on new applicants that is confidential in nature. If employees of managed care plans and advocacy groups worked in HCFA for several months, they might have inappropriate access to this confidential information. If such a training/exchange program were to be initiated, we would need to be sure that the confidential information is not accessible to non-Federal employees who are working as HCFA staff.

Technical Comments on (OEI-01-96-00191)

At the top of page 6, the report states that the review protocol does not differentiate between plans paid on a risk basis versus those paid on a cost basis. This is mentioned again on page 14, in the first paragraph of the recommendation. Please note that the BBA provides that: (1) no new cost contracts can be signed; and (2) current cost contracting managed care plans can continue under the cost option only through 2002.

At the bottom of page 6, the report states that HCFA staff used data on a plan's rapid disenrollment rate to focus the on-site review on the plan's sales practices and incentives, which led to requirements that the plan take corrective action. On page 16, in the second recommendation on that page, the report states that OIG has recommended in the past that HCFA use disenrollment rates to target HMO reviews. We note that, during deliberations on both the 1995 and the 1997 budget reconciliation bills (which included lengthier "lock-in" provisions), HCFA has stressed: (1) the value of monthly disenrollment as a means for identifying plans with high disenrollment rates; and (2) the use of high disenrollment rates as a trigger for more focused plan review to identify problems causing beneficiaries to disenroll at high rates. In spite of HCFA's strong support for retaining monthly disenrollment, the BBA places constraints on beneficiary options to disenroll. Specifically, the current monthly disenrollment policy is retained through 2001. However, beginning in 2002, beneficiaries will be locked-in for longer periods of time: 6 months in 2002, and 9 months thereafter. After 2001, monthly disenrollment does remain an option for newly eligible beneficiaries during the first 12 months of enrollment in a plan.

APPENDIX B

ENDNOTES

1. Health Care Financing Administration, Medicare Managed Care Contract Report, December 1994 and August 1997. The data shown cover only risk plans, cost plans, and health care prepayment plans. Beneficiaries also may enroll in demonstration projects, such as the Social Health Maintenance Organization.
2. An additional form of managed care, Health Care Prepayment Plans (HCPPs) are paid in a similar manner as cost plans but do not cover the Medicare Part A services.
3. Under the terms of the Balanced Budget Act of 1997, cost-based plans are being phased out. No new cost contracts may be signed, and current cost contracting plans can continue under the cost option only until 2002.
4. For some years, senior HCFA officials have considered moving to a more frequent review. The agency, however, has not implemented this change. See, for example, HCFA Administrator Bruce C. Vladeck, "Testimony before the Special Committee on Aging, U.S. Senate," August 3, 1995.
5. The HCFA issued new regulations on appeals processing on April 30, which means plans likely will encounter even more difficulty with appeals processing as these changes are implemented.
6. Department of Health and Human Services, Office of Inspector General, *Medicare Risk HMO Performance Indicators*, OEI-06-91-00734, October 1995. It is important to note, that under the Balanced Budget Act of 1997, the current disenrollment policy is retained through 2001. Beginning in 2002 beneficiaries will be locked-in for longer periods of time: 6 months in 2002, and 9 months thereafter. New enrollees will be able to use monthly disenrollment during the first 12 months of their enrollment in a plan.
7. Our companion report, *Medicare's Oversight of Managed Care: Implications for Regional Staffing*, OEI-01-96-00191, addresses this issue in more detail.
8. Social Security Act §1855 (d).
9. Department of Health and Human Services, Office of Inspector General, *Medicare Risk HMO Performance Indicators*, OEI-06-91-00734, October 1995.
10. Department of Health and Human Services, Office of Inspector General, *Medicare HMO Appeal and Grievance Processes: Overview* OEI-07-94-00280, October 1995.