Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE'S OVERSIGHT OF MANAGED CARE:

IMPLICATIONS FOR REGIONAL STAFFING

JUNE GIBBS BROWN
Inspector General

APRIL 1998
OEI-01-96-00191

OFFICE OF INSPECTOR GENERAL

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OEI's Boston Regional Office prepared this report under the direction of Mark R. Yessian, Ph.D., Regional Inspector General. Principal OEI staff included:

Region

Russell Hereford, Ph.D., *Project Leader*
Nicola Pinson
Kenneth Price

Headquarters

Stuart Wright, *Program Specialist*

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EXECUTIVE SUMMARY

PURPOSE

To assess how the Health Care Financing Administration's regional offices are staffing to meet the challenges of monitoring the growing number of managed care plans that have Medicare Contracts.

BACKGROUND

The scope and speed of growth in Medicare managed care presents fundamental challenges to HCFA staff responsible for oversight of managed care plans. 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 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.

Regional staff confront a much broader set of responsibilities as they oversee managed care plans than they faced in the traditional Medicare fee-for-service program. For example, they may need to evaluate multiple aspects of plan operations such as the quality of services delivered, finances, marketing, and beneficiary access to services.

Our review is based on data on staffing levels provided by HCFA regional offices and on interviews with those staff, as well as with representatives of managed care plans and beneficiary advocacy organizations.

FINDINGS

The HCFA regional offices have made a strong commitment to increase staffing for managed care oversight.

In response to an increase from 244 to 336 Medicare managed care plans between December 1994 and December 1996, HCFA regional managed care staff doubled from 59 to 120 people.

The number of managed care staff grew in every region, with increases ranging from 3 to 11 staff.

However, the vast majority of the new staff lack experience with managed care.

Only 3 of the 71 staff hired in the last 2 years have work experience in health

maintenance organizations.

Sixty of these staff came from other components of HCFA, with experience primarily in the fee-for-service program. Although these staff are highly knowledgeable about Medicare, they do not have an extensive understanding of the managed care system.

The newness of the staff to managed care indicates a need for training to carry out effective oversight. However, data provided by eight regional offices show that funds for training managed care staff decreased from an average of $784 per person in fiscal year 1995 to $396 per person budgeted for fiscal year 1997.

The managed care units in many regional offices lack staff with specialized backgrounds that could enhance oversight of managed care plans.

Five of the 10 regional offices lack staff with clinical backgrounds. Of the 120 staff working in managed care, only 13 have clinical backgrounds.

Five of the 10 regional offices lack staff with work experience in health maintenance organizations. Only seven of the 120 staff have such experience.

Four of the 10 regional offices lack staff with data analysis skills. Only nine of the 120 staff have training and experience with data analysis.

RECOMMENDATIONS

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

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.

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

COMMENTS ON THE DRAFT REPORT

The HCFA provided comments on the draft report. The agency concurred with our first two recommendations, and with the intent of our third recommendation. We are encouraged that the agency reports it is moving forward in these areas. We believe it is important that the agency address all aspects of our recommendations. These aspects include substantive training on managed care issues and methods to improve staff's ability to conduct the monitoring process effectively. Our recommendation also seeks to ensure that expertise in managed care, clinical, and data analysis reside in the front line regional offices, as well as in the HCFA central office.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To assess how the Health Care Financing Administration's regional offices are staffing to meet the challenges of monitoring the growing number of managed care plans that have 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 seeing rapid growth in Medicare managed care.

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 IPA type plans grew by almost 90 percent from 133 to 251 plans in August 1997, and group model plans increased by 60 percent from 79 to 125. In contrast, staff model plans grew from 29 to 32.

New Challenges for HCFA Staff

Managed care plans provide health care services using a fundamentally different framework than the traditional fee-for-service program that HCFA operates. The fee-for-service program reimburses individual health care providers according to specific services provided to beneficiaries. Managed care plans, on the other hand, receive monthly capitated payments from HCFA with which they manage both the delivery and financing of health care services.

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 HCFA has a particular responsibility to ensure that beneficiaries' access to services is protected.

Regional staff confront a much broader set of responsibilities as they oversee managed care plans

than they had faced in the fee-for-service program. Staff may need to evaluate multiple aspects of plan operations such as the quality of services delivered, financial arrangements, marketing, and beneficiary access to services. They must have detailed understanding in the complexity of managed care in order for meaningful inquiry into plan operations. They should also be closely attuned to the relationships between doctors, hospitals, and plans in the local health care market.

The HCFA's Organization for Managed Care Oversight

The 10 HCFA regional offices directly oversee the performance of managed care plans, with support from HCFA's central office. Each regional office has substantial latitude with respect to how it organizes for managed care oversight and how it deploys staff. It is important to recognize that oversight of Medicare managed care plans is only one function that the regional offices perform. As demands on the managed care side grow, these offices must continue to carry out their other responsibilities. These other responsibilities include oversight of fiscal intermediaries and carriers, performing and overseeing survey and certification activities, working with States on Medicaid issues, and addressing beneficiary inquiries, among other duties.

Effective July 1997, HCFA reorganized its internal structure. This may well affect how the managed care program is administered in the central office and, quite possibly, in the regions. Under the new organizational structure, many managed care functions are part of the new Center for Health Plans and Providers.

METHODOLOGY

We surveyed the 10 regional offices to obtain information on their staffing levels for oversight of managed care plans.

In addition, we gathered extensive information from site visits to three HCFA regions: Region 6 (Dallas), Region 9 (San Francisco), and Region 10 (Seattle). We also conducted structured telephone interviews with staff responsible for managed care oversight in the other seven HCFA regional offices. In addition, we interviewed staff in the HCFA Office of Managed Care in Baltimore.

We gathered additional information on HCFA's oversight of managed care 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.

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 REGIONAL OFFICES HAVE MADE A STRONG COMMITMENT TO INCREASE STAFFING FOR MANAGED CARE OVERSIGHT.

- **In response to an increase from 244 to 336 Medicare managed care plans between December 1994 and December 1996, HCFA regional managed care staff doubled from 59 to 120 people.**

- **The number of managed care staff grew in every region, with increases ranging from 3 to 11 staff.**

- **Regional managed care officials anticipate modest increases (to 138 staff) through December 1997, even though 70 applications for new contracts are pending as of August 1997.**

Even though the agency faces current budget and resource constraints, the regional offices have increased staff responsible for managed care oversight. This demonstrates HCFA's considerable commitment to meet the growing demands of managed care.

Two ways to look at the impact of increasing the staff are the number of plans and the number of beneficiaries per staff member. The number of plans per staff member decreased from an average of 4.1 in December 1994 to 2.8 in December 1996. The number of plans per staff member ranges from 2.0 in one region to 3.6 in two regions. The average number of beneficiaries per staff member also decreased between December 1994 and December 1996 from 51,320 to 40,067. We recognize that these measures do not fully capture the actual work involved for regional staff. Overall, however, the figures demonstrate an increase in the number of staff dedicated to individual plans and beneficiaries.

An important implication of this growth is the number of new staff in each region. In 5 of the 10 regions at least half the current staff are new to the managed care units since December 1994. Two extreme examples of the dramatic increase in staff are: In one region, staff increased from 1 member in December 1994 to 9 members in December 1996. Another region grew from 4 staff members in December 1994 to 15 members in December 1996.

Regional managed care teams reported they expect a total increase of 18 staff by December 1997. Projected increases range from 0 to 4 staff in each region. Although Medicare contracts with plans will continue to increase, data on projected staffing levels indicate that only limited growth will take place among regional staff.

HOWEVER, THE VAST MAJORITY OF THE NEW STAFF LACK EXPERIENCE WITH MANAGED CARE.

- **Only 3 of the 71 staff hired in the last 2 years have work experience in health maintenance organizations.**

- **60 of these staff came from other components of HCFA, with experience primarily in the fee-for-service program.**

- **The newness of the staff to managed care indicates a need for training to carry out effective oversight. However, data provided by 8 regional offices show that funds for training managed care staff decreased from an average of $784 per person in fiscal year 1995 to $396 per person budgeted for fiscal year 1997.**

Managed care differs from the traditional fee-for-service program that HCFA operates. Oversight of managed care plans requires staff who are familiar with the incentives of managed care, the characteristics of the local health care market, and the different forms that managed care can take (*e.g.*, delegated services, changes in provider networks). Staff should have skills to evaluate multiple aspects of plan operations such as the quality of services delivered, financing, marketing, and beneficiary access to services. Staff may also have to exercise some degree of independent judgement where HCFA regulations and policy have not yet caught up with service delivery in a managed care setting.

Most of the staff joining regional managed care offices have come from a fee-for-service background elsewhere in HCFA. This is a natural pool of talent that the agency draws on to monitor the increasing number of plans that serve Medicare beneficiaries. We are concerned, however, that staff who may have been involved with one aspect of fee-for-service operations within HCFA--for example, dealing with a fiscal intermediary around payment issues, or responding to beneficiary inquiries--confront a much broader set of responsibilities as they oversee managed care plans. Staff told us that detailed information on managed care issues and specific oversight skills would better enable them to ensure that quality services are delivered to beneficiaries.

Staff repeatedly underlined their need for training around oversight activities. Yet, current oversight training for regional staff is minimal. New staff indicated that they, as one staff member stated, "hit the ground running" without any formal training. Another staff member described training activities as, "it's basically on the job training." In perhaps an extreme case, one staff member told us she was hired in November as a plan manager with no prior experience with managed care and no training on specific skills needed for oversight; she was then the primary person in charge of particular plans and conducted her first site visit by January.

Regional staff cited a lack of training as a major constraint in their ability to monitor. Even though the total number of staff has increased, staff members described the strain on the regions of so many new and inexperienced staff. One implication is that the newer staff have to learn how to perform their oversight responsibilities. Equally important, the more experienced staff must often train the new staff while carrying out their own oversight responsibilities, placing stress on their workloads as well.

Staff identified two major areas where training did not adequately prepare them. First, they emphasized weaknesses in training around specific skills involved in conducting oversight. These skills include such exercises as how to interview managed care staff, how to interview

physicians, how to pull and target specific types of samples, and how to review records. Second, they outlined needs for detailed training on managed care itself, including education in areas such as contracts, delegation, the different forms that managed care can take, the incentives of the different systems, and important areas to look for when on-site.

THE MANAGED CARE UNITS IN MANY REGIONAL OFFICES LACK STAFF WITH SPECIALIZED BACKGROUNDS THAT COULD ENHANCE OVERSIGHT OF MANAGED CARE PLANS.

- **Five of the 10 regional offices lack staff with clinical backgrounds. Of the 120 staff working in managed care, only 13 have clinical backgrounds.**

Many of the staff in the regions and plan representatives indicated the importance of clinical insight to understand the actual services delivered to beneficiaries. Current oversight activities focus largely on the review of plan processes (*e.g.*, if the correct papers were signed, if forms were sent out on time). Yet, staff as well as plans repeatedly cited clinical knowledge as an important asset to evaluate quality aspects of managed care. In some regions, staff with clinical backgrounds add an important component of expertise to the managed care unit. Only a few regions viewed access to clinical expertise from outside entities when needed as adequate.

Staff cited two primary areas where clinical expertise could contribute important information to evaluate plan activities. First, oversight of the medical services that plans deny to beneficiaries requires staff to review information that is based on clinical decisions. Current evaluation of service denials focuses on information such as whether the plans sent appeals language to beneficiaries on time. The review does not look at the appropriateness of denials, an aspect of oversight that many staff indicated would greatly contribute to their understanding of the services provided or denied to beneficiaries.

Second, many staff indicated that clinical expertise would benefit the review of plan medical policies. The services that a plan delivers to beneficiaries depends entirely upon the plan's medical policies. Because one of the incentives of managed care is to limit services, understanding plan medical policies provides fundamental information to evaluate the quality of services that they provide. However, regional staff reported that no one from HCFA reviews or approves plan medical policies.

Several plans indicated that HCFA needs to move the focus in oversight measurements from procedural issues toward clinical outcome measurements. A representative of one plan stated, "They're still looking at it like it's fee-for-service: they look at claims, audit finances, and check to see that processes are followed." However, managed care calls for closer attention to clinical concerns, especially since the same organization that HCFA pays is also in charge of the delivery of care.

- **Five of the 10 regional offices lack staff with work experience in health maintenance organizations. Only 7 of the 120 total staff have such experience.**

Effective oversight of managed care plans requires staff with familiarity in the intricacies of the

managed care environment. One representative of an advocacy group summarized this knowledge base as "understanding what to look for, how to identify problems, where the pressure points are, what the problems are likely to be, and how to deal with those problems."

The HCFA staff, plan representatives, and members of the advocacy community recognized substantial variation in regional experience with managed care plans. Advocacy group members told us that more mature regions are doing a good job of oversight because of their familiarity with the managed care system. However, they questioned the extent of managed care knowledge in the other regional offices. In the regions where managed care has emerged at a rapid rate since 1994, staff are largely new to the managed care field. They confront substantial challenges in both the complexity of the system, and the size of their workload.

Both managed care and regional officials informed us that regional staff with knowledge in managed care would provide for more effective and meaningful oversight of plan operations. In this regard, several plans raised frustrations over the limited HCFA staff experience in managed care.

- **Four of the 10 regional offices lack staff with data analysis skills. Only 9 of the 120 total staff have training and experience with data analysis.**

Effective use of data is becoming increasingly imperative for HCFA to manage oversight of the growing numbers of plans with which the agency has contracts. Already, HCFA collects a substantial amount of information that could be used to keep track of plan activities. (Our companion report *Medicare's Oversight of Managed Care: Monitoring Plan Performance*, OEI-01-96-00190, addresses the opportunities for HCFA to use data for oversight purposes.) The HCFA is also moving toward a data driven system with the introduction of both HEDIS 3.0 and CAHPS in 1997.

Based on interviews with regional staff, we identified four ways that data could be used to assess plan performance: 1) Monitoring internal trends in plan performance over time, 2) Assessing plan performance against regional norms, 3) Comparing plans with other plans in the local market, and 4) Comparing plans with national norms.

Staff who are able to understand and use data play an increasingly critical role in regional offices to make effective use of the information that the agency collects. In one region, for example, all members of the staff are able to understand and analyze data; some members practice basic skills and others possess extensive expertise.

Overall, regional staff told us that they recognized the potential uses of data for oversight purposes, yet they underlined the lack of current skills among staff in the office to make use of this data. One staff member summarized, "We have to stop and look at skill sets. We can't just keep throwing bodies at the work load. We need to have a data person."

RECOMMENDATIONS

The HCFA is now experiencing a major shift into managed care. Both the number of managed care plans and the number of beneficiaries covered by these plans are expanding rapidly. Historically, however, HCFA has been an agency oriented toward fee-for-service claims processing. Our review shows that nearly all of the staff who currently have responsibility for oversight of managed care plans within the HCFA regional offices come from that fee-for-service background within the agency.

We recognize that multiple constraints confront the agency as it works to address this paradigm shift: Restrictions of the Federal personnel system, hiring freezes, and ongoing budget restrictions limit the agency's flexibility in this regard. Nevertheless, the agency must address the implications that the changing health care marketplace has on the type of staff needed to provide oversight. The recent reorganization of HCFA recognizes this changing world and is one effort to address it. We believe that the reorganization provides opportunity also to address the staffing needs for overseeing managed care.

We also recognize that the Balanced Budget Act of 1997 (P.L.105-32) poses a number of challenges for the agency in general, and staff involved with managed care in particular. The demands of the new Medicare+Choice program make it of pressing importance that the agency have staff with the skills needed to implement, track, and evaluate this important new initiative.

We focus our recommendations to urge HCFA to increase and improve the knowledge and skill levels of its staff around the intricacies of managed care issues. We believe that it is important to enhance the ability of these staff to conduct effective oversight of managed care plans. In areas of the country where the managed care market is mature and staff have experience in these issues, the need may be somewhat less critical. Indeed, we urge HCFA to draw on the expertise of staff from these regions as the agency develops its work in this area.

THE HCFA SHOULD DEVELOP, COORDINATE, AND PROVIDE A COMPREHENSIVE TRAINING PROGRAM FOR REGIONAL OFFICE STAFF WITH RESPONSIBILITY FOR OVERSIGHT OF MANAGED CARE PLANS.

We believe it is essential that HCFA make a substantial commitment in this area. Without such a commitment, we are seriously concerned that the agency's oversight efforts could be seriously compromised.

We believe that the HCFA central office should serve as the focal point for this effort, because of its national overview of the Medicare managed care program. This training program should be a broad-based effort that addresses multiple aspects of managed care delivery and financing. During our discussions with regional office staff, we heard of multiple topics that should form the basis for such training. These suggestions included comprehensive training on organization, financing and management of managed care plans; understanding utilization management protocols; interviewing techniques; sampling strategies; and methods of investigation.

This training program should involve faculty members external to the HCFA central office staff. Both the design and the conduct of the training program should draw on multiple sources of faculty, in particular:

- The HCFA regional office staff who have substantial experience in managed care oversight. Those staff who have been performing hands-on oversight and establishing innovative approaches to that task can bring real life experience to the unique issues and concerns that must be addressed in performing effective oversight of managed care plans.

- Representatives of the beneficiary advocacy community. Beneficiary advocacy groups bring concerns and viewpoints to Medicare managed care that will be found neither within the HCFA staff nor within the managed care plans. Advocates often are on the front lines in helping beneficiaries deal with the complexities of negotiating problems with managed care plans. As a result, they can provide HCFA with clear insights into understanding the managed care industry from beneficiaries' points of view.

- Representatives of the managed care community. Staff of managed care plans may be in the best position to educate HCFA staff on the nuances of how managed care is organized and delivered. This source of expertise could provide a firm educational foundation for the HCFA staff.

The HCFA can be flexible in how it establishes and conducts these educational sessions. We encourage the agency to examine alternate formats, including central site conferences, single or multi-regional training sessions, and video conference formats.

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.

Having these types of skills available as a staff resource will provide important avenues of insight for HCFA as the agency carries out oversight of managed care plans. As we note above, we recognize the constraints of the Federal personnel system and the ongoing budget restrictions under which the agency operates. Nevertheless, we believe that effort is warranted to fill at least some open positions by attracting individuals with these skills as a way to complement the existing expertise of HCFA managed care staff.

WE RECOMMEND THAT HCFA DEVELOP A PILOT PROGRAM TO PROVIDE OPPORTUNITIES FOR STAFF DEVELOPMENT AND STAFF SHARING WITH MANAGED CARE PLANS AND WITH BENEFICIARY ADVOCACY GROUPS.

Hands-on experience with managed care plans can provide HCFA staff with important understanding of how this delivery system works. A number of the managed care plans that we interviewed indicated their willingness to participate in such an effort. From their point of view, a monitoring staff that is expert in managed care can be expected to provide efficient and meaningful oversight. We see no reason that this concept could not also be extended to

beneficiary advocacy groups.

Our recommendation encourages HCFA to explore in detail some type of internship or staff exchange program with managed care plans or advocacy groups. We believe that the benefits of such an approach could be achieved by encouraging selected HCFA staff to work for a limited time--6 months, for example--with an advocacy group or managed care plan. Vice versa, staff from those organizations could also serve an internship at HCFA for some period of time. The outgrowth of such an effort would be to enhance the sharing of information among the different organizations and, from HCFA's point of view could well lead to increased skills and knowledge in assessing managed care plans' operations.

We believe that any such pilot effort should contain an evaluation component. If the evaluation shows positive benefits from this program, we believe that HCFA would wish to expand it more broadly.

COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the Health Care Financing Administration (HCFA). In this section, we summarize the major thrust of the agency's comments regarding our recommendations, and we offer our response in italics. The HCFA's complete comments appear in Appendix A.

Comprehensive training

The HCFA concurs with our recommendation. The agency reports that it established a training program in 1997 that addresses many areas of Medicare health plan operations. *We are encouraged that the agency has moved forward with a training program. However, we believe this type of training should include subjects in addition to those that HCFA describes in its response. As we noted in the draft report, HCFA staff responsible for monitoring plans identified a number of additional topics that they view as important to effective oversight. These topics comprise two broad areas: (1) substantive issues related to managed care, such as utilization management, organization, and financing of plans; and (2) methods to improve the monitoring review itself, such as interviewing techniques, sampling strategies, and methods of investigation.*

Staff expertise and experience

The HCFA concurs with our recommendation. The agency reports that it is significantly expanding the central office capacity to address managed care issues. The agency also indicates that it will attempt to seek out staff in the regional offices with clinical and managed care experiences as transitions take place there. *We are encouraged that the HCFA central office is enhancing its capacity around data analysis in the managed care field. We view data analysis as an essential element of effective overnight. We recognize that there are many organizational changes arising from HCFA's recent reorganization, and we trust that these changes will be beneficial for the managed care programs that the agency oversees.*

Our recommendation focused on the need to enhance analytical, clinical, and managed care capacity at the regional office level. As the changes in staffing filter from central to regional operations, we urge the agency to ensure that the commensurate skills and expertise reside there.

Pilot Program

The HCFA concurs with the intent of this recommendation. The agency cites its implementation of some staff rotation and internship experiences. The HCFA also cites difficulties the agency might encounter in carrying out this recommendation, such as concerns about confidentiality of information from health plans. *We are encouraged that the agency is taking steps to establish staff development and staff sharing programs with managed care plans. Our recommendation calls for a pilot program to assess the feasibility of these staffing innovations, and we call for an evaluation component to that program. Certainly, the evaluation should address the extent to which the concerns that HCFA describes in its comments are serious obstacles to implementation.*

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: Monitoring Plan Performance," (OEI-01-96-00190).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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

GROWTH IN MEDICARE MANAGED CARE

December 31, 1996			
Regional Office	Medicare Contracts	Beneficiaries Enrolled in Managed Care	Regional Managed Care Staff
1 Boston	24	199,597	8.5
2 New York	38	424,040	10.5
3 Philadelphia	31	486,138	15.5
4 Atlanta	47	632,446	18
5 Chicago	51	394,772	16
6 Dallas	32	342,632	9
7 Kansas City	18	103,873	6
8 Denver	16	146,206	7
9 San Francisco	55	1,737,655	20
10 Seattle	24	320,596	9
TOTAL	336	4,787,955	119.5

December 31, 1995			
Regional Office	Medicare Contracts	Beneficiaries Enrolled in Managed Care	Regional Managed Care Staff
1 Boston	20	134,085	5.5
2 New York	25	284,854	7.5
3 Philadelphia	26	289,936	7.5
4 Atlanta	33	500,354	16
5 Chicago	45	309,573	10
6 Dallas	22	250,463	8.5
7 Kansas City	13	71,030	6.5
8 Denver	17	122,650	3
9 San Francisco	49	1,573,082	16
10 Seattle	23	271,291	7
TOTAL	273	3,807,318	87.5

December 31, 1994			
Regional Office	Medicare Contracts	Beneficiaries Enrolled in Managed Care	Regional Managed Care Staff
1 Boston	16	87,738	3.5
2 New York	21	200,914	6
3 Philadelphia	25	184,714	4
4 Atlanta	27	396,558	13
5 Chicago	41	284,099	9
6 Dallas	18	138,621	1
7 Kansas City	13	56,357	3
8 Denver	17	103,372	4
9 San Francisco	45	1,381,915	10
10 Seattle	21	219,226	6
TOTAL	244	3,053,514	59.5