U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

INTERNATIONAL MEDICAL CENTERS SERVICE DELIVERY EVALUATION

OFFICE OF

ANALYSIS AND INSPECTIONS

INTERNATIONAL MEDICAL CENTERS
SERVICE DELIVERY EVALUATION

RICHARD P. KUSSEROW
INSPECTOR GENERAL

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Office of Inspector General

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This Report

Entitled "International Medical Centers Service Delivery Evaluation," this study was conducted at the Health Care Financing Administration's (HCFA) request to obtain, in an objective way, Medicare enrollee attitudes about services and medical care received from and through International Medical Centers (IMC). IMC is the largest Medicare HMO in the nation.

The report was prepared by the Office of Analysis and Inspections, Region IX and Headquarters, Health Care Branch. Participating in this project were the following people:

San Francisco Region	Headquarters
Thomas Purvis (Project Leader)	Mary Hogan (Project Leader) Karen Reynolds

Atlanta Region Staff

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EXECUTIVE SUMMARY

Since 1982, risk-based health maintenance organizations (HMOs) have grown to be major providers of health care to Medicare beneficiaries. The Health Care Financing Administration (HCFA) pays these HMOs on a capitation basis, in which an HMO receives a fixed amount for each Medicare beneficiary it enrolls, in return for the provision of all covered health care services to these people. While an incentive for efficiency, this arrangement also creates the potential for diminished quality of care if the HMO sacrifices services in order to cut costs. The Office of Inspector General (OIG) conducted this evaluation to determine, in an objective way, Medicare enrollee attitudes about the services and medical care they had received from International Medical Centers (IMC). This was one of many OIG initiatives to examine various aspects of IMC in response to the Department's interest in resolving numerous complaints about IMC's services to beneficiaries.

In order to gain experience with the concept of risk-based contracting with HMOs for Medicare services, HCFA selected 32 HMOs (including IMC) to serve as demonstration projects. Effective August 1982, IMC began enrolling Medicare beneficiaries under these provisions and quickly achieved rapid growth in their numbers through a variety of aggressive marketing strategies. These included: intense media coverage featuring endorsements from celebrities, bounty payments to members to facilitate word-of-mouth endorsements and sign-ups by friends, and personal appeals at senior centers and other such gatherings. IMC has grown to have the largest Medicare beneficiary enrollment of any risk contract HMO in the nation, with 137,814 Medicare beneficiaries enrolled as of May 1986. These people represent about one-fifth of the total national Medicare beneficiary enrollment in risk-based HMOs.

IMC's initial operations were in the Miami, Florida area. Its rapid growth was accommodated through expansion to a highly decentralized network model of 186 affiliated provider groups covering five Florida counties. Seven of these affiliates were wholly-owned by IMC, but the remaining 179 were private entities under contract to IMC. The sizes and financial viability of the affiliates varied, and the per capita reimbursement paid by IMC to each of them was substantially less than the amount IMC received from HCFA. In addition, most of these affiliates exceeded the statutory limit (presumed to prevent quality of care problems) that no more than 50 percent of their membership be Medicare and Medicaid enrollees. (In April 1985, HCFA had granted IMC a 3-year exemption from this requirement, in an extension of one of its terms as a demonstration project.)

In mid-1986, a random sample of 351 current and former IMC Medicare beneficiary members was selected from HCFA records to be interviewed. OIG was able to complete interviews (by telephone and/or mail) with 290 (83 percent) of the sampled beneficiaries.

These beneficiaries were asked to summarize their overall satisfaction with IMC. Major findings included:

- Almost two-thirds of the people contacted (188 of the 290) expressed some level of satisfaction with IMC.

- Those members (23 percent) who expressed dissatisfaction complained about difficulties in getting specialist care, care that did not meet their expectations, problems with drug prescriptions, their assignment of physician, and difficulties with payment for services received outside the geographic area served by IMC.

- Of the 17 percent who were very dissatisfied (50 people out of the 290 contacted), most (36 people) had already terminated their IMC membership.

- Through adverse publicity, reported investigations, and high staff turnover, members were aware that problems existed with IMC. They were concerned about the effects this situation might have on what most considered to be a satisfactory health care arrangement.

- IMC members used fewer services and were hospitalized at a much lower rate than the Medicare population in general. This indicates that the capitation payment which HCFA makes to IMC may have been set higher than appropriate.

- Some beneficiaries claimed that IMC affiliates sometimes refused to provide certain services covered by Medicare, and in two reported cases, openly encouraged beneficiaries to cancel their memberships just long enough to have Medicare pay for those services.

- Most beneficiaries interviewed by telephone (152 out of 189) recalled receiving information on how to use IMC's services (usually in the form of a brochure). However, about a third of these beneficiaries indicated that there were aspects of IMC's medical coverage that they did not fully understand.

- For many beneficiaries, saving money through their enrollment in IMC was more important than any perceived shortcomings in the quality of care they received.

The following OIG recommendations were made to HCFA:

- Since many beneficiaries indicated that there are aspects of IMC's medical coverage that they do not understand, HCFA should develop standards for disclosure by IMC of the limits and exclusions to its coverage.

  HCFA agreed in principle with this recommendation, noting that they had strengthened the notice of enrollment to new

HMO members. However, due to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires HCFA to review all HMO marketing material, they felt that additional changes were unnecessary at this time.

- HCFA should revise its lock-in notice to new enrollees to advise them that Medicare is making a monthly payment to the HMO on their behalf, and to remind beneficiaries of their right to complain if they receive inferior care.

  HCFA concurred with this recommendation.

- In light of the number of IMC members who spend more than 60 days each year away from the IMC service area, HCFA should re-examine its current policy for HMO out-of-plan services.

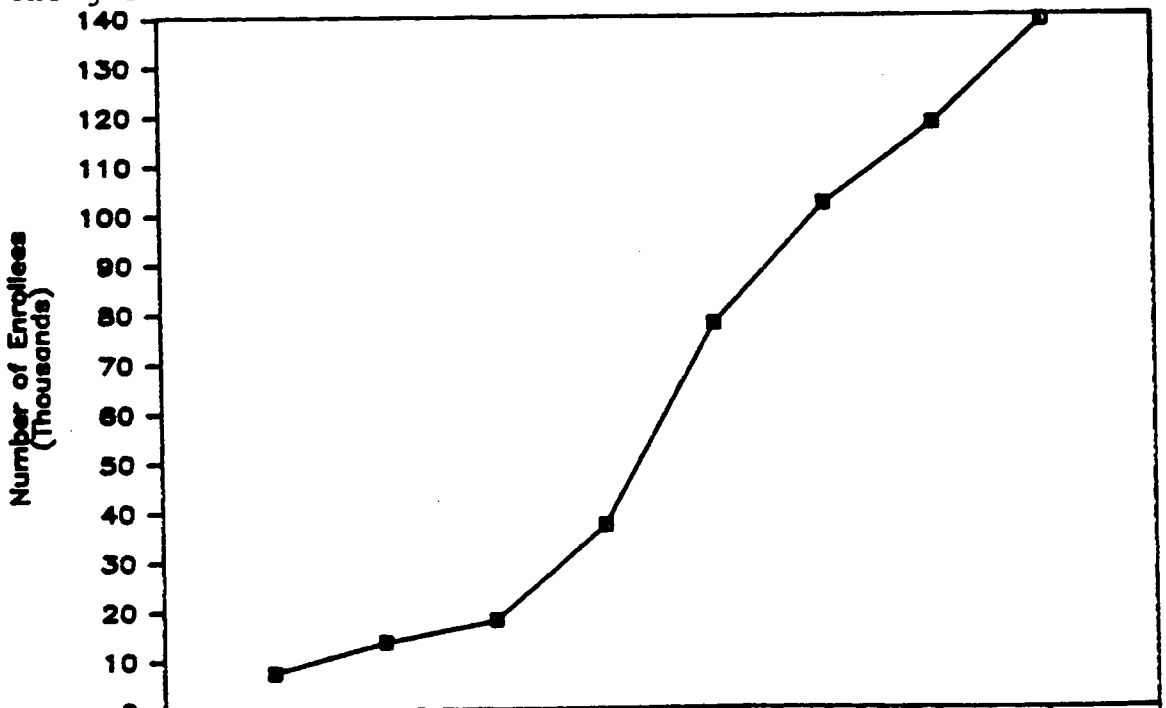
  HCFA did not concur with this recommendation, noting that the lock-in provision is a basic premise of the HMO concept. Furthermore, since HMOs are an alternative to the fee-for-service system, Medicare beneficiaries who are disadvantaged by this provision have the choice not to enroll in an HMO.

I. BACKGROUND

International Medical Centers (IMC) began business initially in the Miami, Florida, area. In 1981, it began enrolling Medicare beneficiaries under a Medicare cost reimbursement contract. In 1982, it was selected as one of several HCFA HMO risk-sharing demonstration projects. As a risk contractor, IMC was guaranteed a standard monthly payment for every Medicare beneficiary it enrolled. Another important feature of this project was HCFA's waiver of the statutory requirement that the percentage of IMC's Medicare beneficiary enrollment could not exceed 50 percent of the total membership. This requirement is perceived as a quality assurance measure since "commercial clients" will not enroll or stay in a poor-quality plan.

Risk contract operations began in August 1982 with about 7,000 members. This number grew to 18,000 by July 1983 and in the following year quadrupled to 78,000 by July 1984. In the months of January and February of 1984, approximately 30,000 new beneficiaries enrolled. As of May 1, 1986, IMC's Medicare enrollment was 137,814, down from a high of 139,120 in January 1986. IMC had expected to enroll about 202,400 Medicare beneficiaries by March 1988. However, IMC capped its Medicare enrollment at mid-1986 levels in response to criticism it received for not actively working towards the March 31, 1986 deadline that no more than 50 percent of its enrollment be comprised of Medicare beneficiaries. According to HCFA records, IMC Medicare enrollment represents about one-fifth of the total national Medicare enrollment in risk contract HMO's.

The following graph, using data developed by OIG, illustrates the growth in IMC's Medicare beneficiary membership.



More detailed profile information of IMC can be found in Appendix A.

IMC became highly decentralized, providing services through a "network" model of affiliated groups of physicians and hospitals. Seven of these 186 affiliates were wholly-owned by IMC, and the other 179 were under contract.

Under these contract arrangements, IMC is to pay a Part B capitation amount and a Part A supplemental capitation rate to each affiliate every month. These amounts vary by affiliate, but average $69.75 for the Part B capitation rate, and $17.69 for the Part A supplemental rate, a total ($87.44) which is substantially less than the amount that IMC receives from HCFA (approximately $300). However, this amount only covers the nonhospital care which the affiliate must provide, either directly or by contract to a third party provider; hospital costs are shared between the affiliate and IMC.

The following table shows the number of contract affiliates in each IMC Florida county, and the average rate received by the affiliates from IMC for Part B in April of 1986. These were obtained from the Office of Health Maintenance Organizations' Part B reimbursement report.

County	Number of Contract Affiliates	Part B Capitation Rate	Part A Supplemental Rate
Broward	49	$75.97	$25.52
Dade	66	$92.39	$23.20
Hillsborough	19	$56.56	$12.15
Palm Beach	23	$74.12	$14.01
Pasco	8	$50.02	$12.64
Pinellas	14	$53.77	$12.20
All counties	179	$69.75	$17.69

In the past 2 to 3 years, an ever-growing number of complaints have been submitted by IMC Medicare members, affiliated group physicians and outside providers serving IMC members. These complaints highlight major problems and have put IMC under close scrutiny by Federal and State agencies. The complaints and allegations concern IMC practices in such areas as marketing, risk-sharing with

providers, claims payments and the delivery of medical care, and have been subject to high congressional and media interest.

II. PURPOSE

The purpose of this evaluation was to determine, in an objective way, enrollee attitudes about services and medical care received from and through IMC. In light of the many complaints received about IMC, this evaluation was undertaken to determine (1) whether complaints received about IMC reflect widespread and pervasive dissatisfaction among the general IMC membership, (2) the extent to which IMC operations may have adversely affected its members and, (3) areas where additional HHS action may be needed.

III. METHODOLOGY

HCFA's Group Health Plan Master File served as the initial data source for this evaluation. This file, maintained by the Bureau of Data Management and Strategy, contains beneficiaries who have participated in group health plans, including HMO's. Two samples were drawn from this file. The first, a 20 percent sample (38,512) of all Medicare beneficiaries in IMC, was used to profile IMC membership. The second was a 0.2 percent sub-sample of 351 living beneficiaries, who were selected to be interviewed.

Both samples were selected at random, based on the terminal digits of the Health Insurance Claim Number. This methodology was used because samples drawn in this way are weighted in the same way as the universe, and therefore minimize the potential for drawing a biased sample based on some preconceived notions about the universe.

Given the short time frame of this evaluation, it was determined that the only practical way to reach these 351 sample beneficiaries, who were scattered over several counties in Florida, was by telephone. In addition, a few had out-of-State addresses.

A discussion guide was developed for use in the telephone interviews and revised after a pretest. A two-phase study was then conducted. In phase one, 189 telephone interviews were completed.

Initial attempts to reach 162 of the 351 beneficiaries were unsuccessful, either because they declined telephone interviews or could not be contacted despite repeated attempts. In phase two, we followed up by sending an abbreviated set of questions by registered mail to these people. Our findings from telephone discussions and mailed questionnaires are discussed below.

We were concerned that the results from the sample might be biased to the telephone interviews and, therefore, conducted an analysis of four known variables in both the "telephoned" and "not telephoned" populations. The results of this analysis are outlined in Appendix B. Our analysis showed that the distributions of these variables in the "telephoned" and "not telephoned" groups were not significantly different; therefore, we do not expect that the basic results of the survey would have been different if we had asked all of the questions of both groups.

The following table provides a summary breakdown of the disposition of the sample:

	Number	Percent
Total Sample	351	100.0%
Questioned by telephone	189	53.8%
Questioned by mail	101	28.8%
Refused questioning	52	14.8%
Unable to locate	9	2.6%

We were unable to locate 9 beneficiaries from the original sample (less than 3 percent of the total) because they do not live at the addresses on record with the Health Care Financing Administration or with the Social Security Administration. To verify the existence of these beneficiaries, these cases have been referred to our investigation staff for resolution.

IV. FINDINGS

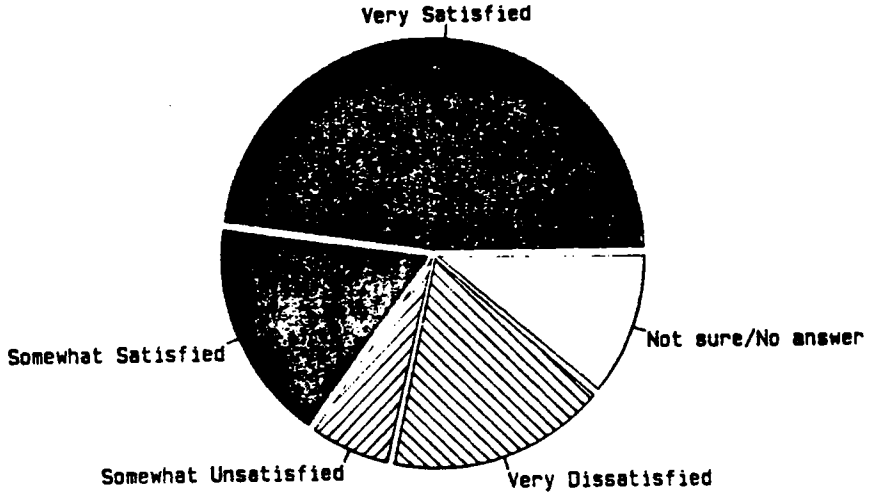
A. Overall Satisfaction with the Plan

Beneficiaries contacted by telephone and by mail were asked to summarize their overall satisfaction with IMC; their answers are displayed in the following table and graph.

Level of Satisfaction	Number of Beneficiaries	Percent
Very Satisfied	138	48%
Somewhat Satisfied	50	17%
Somewhat Dissatisfied	19	6%
Very Dissatisfied	50	17%
Not Sure	11	4%
No Answer	22	8%
Total	290	100%

Almost two-thirds of the sample beneficiaries expressed some level of satisfaction with IMC. Of the 50 beneficiaries who said they were very dissatisfied, 36 had terminated their memberships.

Beneficiary Satisfaction with IMC



(n = 290)

One of the issues the study was designed to resolve was whether there would be a difference in perceived satisfaction with services between those with extensive need for medical care and those who are essentially healthy, with little or no service utilization history. This issue was not fully resolved by this evaluation.

The following table depicts responses to the question, "Have you had a serious illness or surgery since you joined IMC...?"

Response	Number of Beneficiaries *	Percent
Had serious illness since enrolling	49	25.9%
Had no serious illness since enrolling	116	61.4%
No answer	24	12.7%

* This question was only asked of telephoned interviewees.

Another factor that should be considered has to do with the beneficiaries' interpretation of the terms "serious illness or surgery." In most cases, beneficiaries qualified their "yes" answers with an explanation. About two-fifths of these explanations indicated acute problems such as fractures and infections, or minor surgeries, often performed on an outpatient basis, such as eye surgery, "lumpectomies" or hernia operations. With this taken into consideration, only 30 beneficiaries had chronic problems or major surgery, including heart disease and open heart surgery, prostate surgery, cerebral palsy, leukemia and other cancers.

One hundred and sixty-four (of 189) beneficiaries responded to both the "satisfaction" and "serious illness" questions. A cross tabulation of their responses appears below.

	No major illness/surgery	Major illness/surgery
Satisfied	104 (78 percent)	18 (60 percent)
Dissatisfied	30 (22 percent)	12 (40 percent)

Chi-square=3.12, p=0.08

The above data suggests that healthier IMC enrollees are likely to be more satisfied with the HMO than sick people. However, this difference is not statistically significant (a p value of 0.05 or less would indicate significance).

One of the difficulties in measuring the satisfaction levels of IMC-member beneficiaries stems from its structure. Since IMC is comprised of many affiliate groups, we are not really measuring satisfaction with one medical service entity. As one beneficiary commented, "I think [satisfaction] depends on which clinic you go to. I've heard some bad things, but my doctor is fine."

The HMO appears, from the beneficiary viewpoint, to meet their concerns about the high cost of health care. Many beneficiaries expressed fears that bad publicity might have a detrimental effect on what they consider to be a satisfactory arrangement.

The interviews were conducted after and during a period when publicity about IMC appeared on television and in newspapers almost every day. For example, in late May, a Tampa television station presented a four-part series on IMC, highlighting numerous examples of short-falls in quality of care. This publicity frightened many of the members we interviewed.

The following are representative of the many comments volunteered by beneficiaries:

- "The office we go to has only one doctor - it used to be packed full, but with all the publicity people are scared, and the clinic is empty, or only one or two patients - people are going back to Medicare."

- "So far we are happy, but we see a lot of bad things about it on T.V. We can't afford high-priced doctors. We are both near 80 and live on a fixed income. We are still healthy, so far, thank goodness."

B. Enrollment

Of the 290 beneficiaries who responded to our survey by telephone or mail, 220 (76 percent) were still members of IMC. On the average, these beneficiaries had been members for 22 months. One hundred and seventy (170) or 59 percent

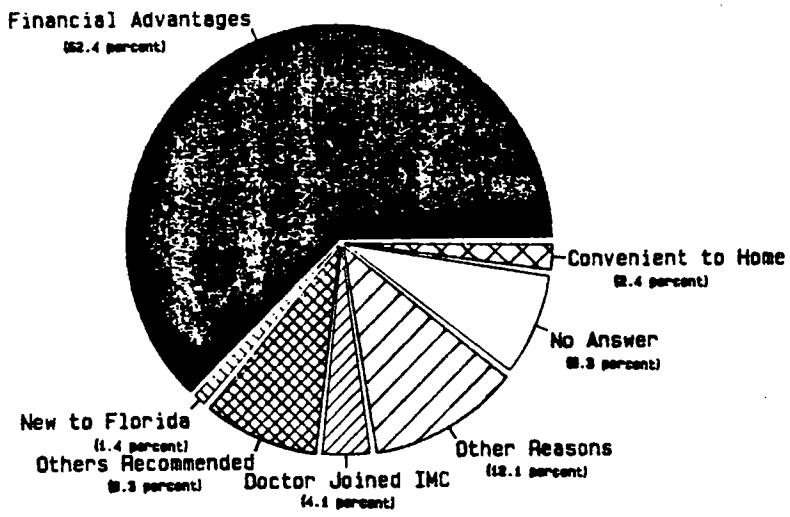
of the interviewees had been members for more than a year, and 11 beneficiaries had been with IMC since its inception in August of 1982.

Many of the beneficiaries we questioned viewed IMC's plan as a comprehensive health insurance package. In fact, three of them volunteered that they believed the plan covered catastrophic illness. One of these beneficiaries dropped out of the plan when she learned that long-term (nursing home) care was not covered; the other two beneficiaries are still members.

In addition, about two-thirds of the beneficiaries we interviewed stated that the financial advantages of the health maintenance organization structure were the primary reason for joining IMC. Its wide range of services, at no cost to them, met their concerns for limiting out-of-pocket costs for health care.

As depicted in the following chart, about 10 percent of the respondents joined IMC on the advice of a friend or family member, and 4 percent joined when their personal physician affiliated with IMC. Slightly over 2 percent indicated that the HMO was close to home, and about 1 percent indicated that they had recently moved to Florida.

Why Beneficiaries Joined IMC



(n = 290)

Twelve percent gave other reasons, such as "everybody was doing it", "my old HMO closed", and "the HMO had a good reputation for high quality care." Eight percent did not respond to this question.

Responses of the 189 beneficiaries who were interviewed by telephone indicated that mass advertising clearly does pay off in terms of attracting members. Eighty-four respondents (44 percent) said they heard about IMC through advertising on television, radio, and in newspapers. Five beneficiaries specifically mentioned a personality endorsement, naming such people as Glenn Ford, Barbara Mandrell, and Mike Douglas. The second largest number of beneficiaries signed up after they heard a presentation made by IMC representatives, either at their door or at a special "seminar" or "lecture". One beneficiary, who disenrolled after 10 months, said she was enrolled by a friend who was paid a $50 bounty for signing her up. Both door-to-door solicitation and offering bounties as inducements to join HMO's are prohibited under the risk contract; these cases have been referred to our investigation staff for resolution.

The following table shows the various ways in which interviewed members stated they had heard about IMC:

How Members Heard About IMC

Advertising	84	44%
Friend/family	35	19%
Seminar/lecture	18	10%
Door-to-door	12	6%
Doctor/clinic	12	6%
Other	6	3%
NA/don't remember	22	12%

C. Explanation of Benefits

The 189 beneficiaries interviewed by telephone were asked if they had received information on how to use IMC services, including emergency care and services outside of the plan area. Although 80 percent (152) responded that they did receive information on how to use IMC services (usually in the form of a "brochure"), about one-third volunteered that there were things about IMC membership they did not understand.

The following quotes illustrate knowledge gaps existing among enrollees:

- o "I don't know what services are available under the HMO."
- o "I don't understand what is covered when I am in travel status."
- o "If I had had the right information about how IMC worked, I would not have enrolled."
- o "Everything should have been better explained. I paid for my own drugs for a year, not realizing they were covered."

D. Disenrollment

Twenty-six percent (49) of the 189 beneficiaries we interviewed by telephone, and 21 percent (21) of the 101 we interviewed by mail had disenrolled from IMC. These beneficiaries averaged 9 months of IMC membership but this distribution is skewed; the median length of membership was about 6 months. Eleven beneficiaries cancelled their membership within 60 days of joining, and two beneficiaries were retroactively disenrolled by HCFA.

With two exceptions, all of these disenrollments were initiated by the beneficiaries, without external pressure from IMC. The first exception is a beneficiary who believes he is still enrolled, while HCFA records indicate that he disenrolled in October of 1985. The man cannot read or write, but remembers signing "some papers" from IMC when he was hospitalized or around that time. The second is a woman, listed in HCFA records as having been a member for 7 months, who was particularly vehement in her denial of either enrolling in, or disenrolling from, any HMO. Both these situations have been referred for investigation.

When asked why they disenrolled, 74 percent (52 of a total of 70) expressed their dissatisfaction with an aspect of IMC services. The following chart summarizes beneficiary dissatisfactions:

	Number	Percentages
Quality of care did not meet beneficiary's expectations	18	35%
Other reasons for dissatisfaction with services	13	25%
Required care not available through the plan	8	15%
Inability to see a doctor, especially specialists	7	13%
Wanted personal physician	6	12%

The eighteen beneficiaries that felt the quality of care delivered by IMC did not meet their expectations noted problems that ranged from minor to major complaints.

Minor complaints included statements such as, "The doctors don't speak English" and "The office was dirty..." More serious complaints were characterized as those which may have endangered the patient's health: "The doctor prescribed penicillin, and my husband is allergic to the drug. The doctor never asked about drug allergies" and "The doctor prescribed a dermatological cream. When I told her that the cream made my face swell up, and my eyes puff shut, she wrote me another prescription. The pharmacist told me it was the exact same thing."

Problems with referrals to specialists were cited by both active and terminated members. One woman, who had been unsuccessful in getting an appointment to see a surgeon through IMC, sought and paid for a surgeon herself. She stated that this surgeon had told her that if she had delayed any longer, she would have lost her leg.

Eight beneficiaries mentioned that they required care which they were told was not available through IMC; in four of these cases, the care the beneficiary required is a covered service under Medicare.

Of the 18 disenrolled beneficiaries who did not express dissatisfaction with IMC's services, eight moved away from Florida, five did not answer the question, three said they never enrolled and two enrolled in error.

Beneficiaries who were interviewed by telephone were asked if they requested help in resolving the problems that led to disenrollment. Only a few (12 of 49 who answered the question) indicated they had. Usually their complaints were made to the doctor or to the clinic staff. Most felt they got no help or only very limited help and this lack of response helped convince these members to drop out.

E. Utilization of Services

The telephone discussion guide was designed to enable us to determine (1) what services the beneficiaries were receiving, (2) the beneficiaries' general satisfaction with those services, and (3) whether there were any major categories of problems. No specific utilization questions were included in the mail questionnaire; therefore, analysis in this section pertains only to the beneficiaries who were interviewed by telephone.

The 189 beneficiaries we interviewed by telephone represent (collectively) 3,603 months of membership in IMC. Fifteen (15) of the beneficiaries we interviewed had never received any services from IMC, either because they are new enrollees, they were unable to get an appointment, or they dropped out of the plan after they realized what membership in an HMO means. These 15 beneficiaries represent 67 months of membership, slightly over 4 months per beneficiary. Another 27 beneficiaries have used IMC services only once or twice; they represent 335 months of IMC membership, or an average of 12 months per beneficiary.

The following table shows the number of beneficiaries who reported that they had received particular services, and whether or not they were satisfied with those services.

Services Received by Beneficiaries: Number and Percentage

Type of Service	Satisfied		Dissatisfied		Total
Physical Examination	117	79%	32	21%	149
Eye Examination	89	84%	17	16%	106
Prescription Drugs	119	88%	16	12%	135
Emergency services	39	87%	6	13%	45
Xrays, lab tests	115	91%	11	9%	126
Specialists	47	59%	32	41%	79
Hospitalization	17	89%	2	11%	19

1. Outpatient Services

Approximately eight out of 10 (79 percent) of the beneficiaries we interviewed had received a physical examination, and most of them were satisfied with the quality and thoroughness of that examination. Beneficiaries who were dissatisfied usually felt that the examinations were superficial.

Not all beneficiaries received a physical examination immediately upon enrollment. Thirty-two beneficiaries reported that they did not receive a physical examination within the first 60 days of membership. Only one beneficiary volunteered that a physical was performed prior to her enrollment. ("They sent us to Miami for a physical first. I understand they can't do that anymore.") The scope of this study did not lend itself to determine whether or not IMC prescreens potential members. A much larger sample (at least 6,000 members) would be required in order to identify those kinds of patterns, including which affiliates might be engaging in this practice.

About 56 percent of the interviewees (106) had an eye examination under their coverage with IMC. Most expressed satisfaction with the examination. Those who were dissatisfied gave various reasons for their displeasure, including: the glasses were "ugly", they had specific problems that the doctor did not treat, and delays of up to 5 months for an appointment.

Over 70 percent (135) of the interviewees had received prescription drugs through IMC; 88 percent of these were

satisfied with what they received. Dissatisfied beneficiaries mentioned that the HMO only prescribes generic drugs, dispenses only samples, or requires the beneficiary to wait several days for a refill.

Only 45 beneficiaries reported that they had used emergency services. About 13 percent of these expressed dissatisfaction, mentioning long waits and indicating confusion about where to get these services, and who should pay.

About two-thirds of the beneficiaries (126) reported that they had had diagnostic tests performed, either laboratory tests or x-rays. Most beneficiaries were satisfied with these tests, and 82 percent (103) said that their doctor always explained the results of the test to them.

Seventy-nine beneficiaries had seen a specialist at least once; 40 percent of these indicated some dissatisfaction. This is the highest rate of dissatisfaction we observed with any category of service. Difficulty in getting to see a specialist was the most frequently mentioned reason for dissatisfaction. It appears that few specialists are available for IMC members. Typical comments offered were:

- "I saw a specialist once, and when I called to make a follow-up appointment, I learned that the specialist was no longer with IMC."

- "I couldn't see a urologist because IMC didn't have one available. I waited more months for them to hire one."

2. Inpatient Services

Only 19 (10 percent) of the 189 beneficiaries we interviewed by telephone had been hospitalized. In a total of 23 separate admissions, only two expressed dissatisfaction.

Since hospitalization rates are one indicator of morbidity rates, it is important to note that hospitalization rates in this sample were significantly lower than those in the general Medicare population. This finding indicates that the capitation payment may have been higher than appropriate.

On average, about 25 percent of the general Medicare population will be hospitalized in a given year. If IMC

members were hospitalized at the same rate, we would expect 48 beneficiaries from our sample to indicate that they had been hospitalized (95 percent confidence interval is 42 to 54 beneficiaries). However, only 19 (10 percent of the beneficiaries we interviewed) said they had been hospitalized.

To complete the picture of utilization, we asked beneficiaries whether they had ever been denied services, whether they had ever had to pay for services, and whether they had ever used services outside of the IMC service area.

Twenty-four (16 percent) of the 155 beneficiaries who responded to the question concerning denied services said they had been told that some services were not covered, or were unavailable. Ten of these beneficiaries subsequently disenrolled from IMC. Most of the denials concerned referrals to specialists, for services that are covered by Medicare.

In addition, one woman who required a seat-lift chair reported that IMC told her that they did not cover the chairs. She said the IMC representative suggested that she disenroll and purchase the chair under Medicare, then re-enroll in the plan. This has been referred to our investigation staff for resolution.

3. Beneficiary Payment for Services

Most beneficiaries (137, or 87 percent of those who answered the question), indicated that they had never paid for any services while a member of IMC. Twenty-one beneficiaries had paid for some things, often for upgrading eyeglasses to ones with "nicer frames". Ten beneficiaries paid for services which they sought outside of the plan when IMC would not provide the services, or when they could not get a referral, or when they questioned the treatment that the IMC doctor had prescribed. Examples of services beneficiaries stated they purchased outside the plan are:

- "I had an eye problem, and it required surgery. I was told I would have to go to the clinic and they would arrange for it, but I would rather go to the doctor I know. I went to my doctor, and had the operation, and paid for it myself. I don't understand why I can't go to the doctor of my own choosing."

- "I have a heart condition, and I see a cardiologist twice a year. I pay for these visits myself because I don't feel the competence is there [with IMC]."

4. Out-of-Area Services

Many of the complaints that HCFA and other agencies have received from IMC members concern problems with seeing physicians or obtaining hospital care while the member is out of the area.

According to HCFA records, about 3.5 percent of the active IMC Medicare members were not Florida residents at the time of this evaluation. Ten (or 3.5 percent) of the beneficiaries in our sample had non-Florida addresses. Two died during the survey period. Of the remaining eight, five terminated their IMC memberships and two maintain north/south life styles.

Since many Medicare IMC members are retired, they frequently spend part of the year (usually summers) away from Florida. When they have to use a physician, or go in the hospital on an emergency basis, they are supposed to notify IMC and get authorization, preferably in advance. The same is true for emergency care within the area. Much confusion existed around this issue. Beneficiaries, hospitals and physicians questioned the terms of the member's medical emergency coverage, which resulted in disputes about who was responsible for payment for those services.

Nine of the 139 beneficiaries who responded to the question indicated that they had received some services while outside of the IMC service area in Florida. Four of these beneficiaries had no problem in getting IMC to approve and pay for the care. Three beneficiaries mentioned problems stemming from the definition of emergency care and prior approval. One beneficiary disenrolled in order to get services paid by Medicare: "IMC doesn't cover North Carolina, so I went back on Medicare for the hospitalization, then joined back up with IMC." Another beneficiary offered the comment, "We spend a good part of the year in Connecticut, and the plan doesn't work well when you go out of state, so we disenrolled."

F. Choice of Physician

We questioned beneficiaries about several aspects of service delivery which are common to HMO's in order to determine the respondents' attitudes. Not all beneficiaries answered these questions because some had simply not used IMC's services enough to see any doctor consistently, or to be able to judge how well the HMO works for them.

HMO's are often set up like clinics; that is, the member has no choice of a physician and is seen by any available staff doctor. Most respondents (101, or 53 percent) indicated they were not able to choose the doctor they wanted. Although some beneficiaries felt that their inability to choose their doctor was strong enough reason to disenroll, most said that this did not matter to them (63, or 62 percent).

Even though most beneficiaries did not choose their doctor initially, they generally continued to see the same physician once treatment was started, thus ensuring some consistency of care. Of the 150 beneficiaries who responded to this question, 90 said they saw the same doctor each time they went. Fifty-four saw any available doctor, while six said they usually saw their primary physician, but in emergencies or other situations, would go to any available doctor.

Beneficiaries were asked about how they arranged to see their doctors. Of the 152 beneficiaries who responded to this question, only 5 indicated that they do not make appointments, but just go to the clinic when they need to. The remaining 147 respondents said they usually make an appointment, and about a third of these (52) said that they see their doctors on a regular basis, making the next appointment at the doctor's office. The other beneficiaries said that they call to schedule their appointments.

While this system seems to work reasonably well, some beneficiaries expressed dissatisfaction in getting appointments. This problem seems to be more pronounced when the beneficiary is trying to see a specialist, but a few (17, or 9 percent) indicated that they had to wait 2 or more weeks for an appointment with a non-specialist physician.

V. CONCLUSION

All in all, most survey respondents feel that the concept behind IMC is a good one, and that there are bound to be problems with any new system of health care delivery. While some beneficiaries have encountered problems that they consider serious enough to cause them to disenroll, many others feel that the problems are tolerable when weighed against all of the benefits of membership. In particular, two-thirds of those interviewed mentioned the financial advantages of HMO membership as their primary reason for joining IMC. For many respondents, saving money was more important to their satisfaction with IMC than quality of care.

Respondents' perceptions of the quality of care they received from IMC varied: some found it to be consistently high; others found it so poor that they canceled their memberships. A considerable number had had very little exposure to IMC's services, and therefore were unable to comment on the quality of care. The scope of this study did not permit cross-tabulation of quality of care responses to where the services were received. IMC's structure -- a network of independent affiliates, as well as some wholly-owned by IMC -- may account for the range of opinions on quality of care.

IMC Medicare enrollees appear to be healthier than the Medicare population as a whole. We found most respondents to be alert and articulate. However, although most were aware of the benefits they are entitled to, about a third did not understand one or more aspects of their HMO coverage. This situation may or may not be true for Medicare beneficiaries who are members of other HMO's. Given that HMO's are a new concept in health care coverage for many elderly beneficiaries, HCFA's implementation of our recommendations for strengthening enrollment notices may help to prevent future misunderstandings about coverage provisions.

APPENDIX A

Profiles of IMC's Medicare Enrollment

Profiles of IMC's Medicare Enrollment

A random 20 percent sample of current and former members of IMC was selected from HCFA's Group Health Plan Master file, to be used in developing a profile of that HMO's membership. Membership growth (enrollments and disenrollments), length of membership, and the residence and age of members were examined; the results were presented in the tables that follow.

Table 1 shows the membership growth of IMC from August 1982 to January 1986. The first three columns in this table reflect sample counts and show the number of new enrollees, the number of members who withdrew from IMC (through termination of their eligibility to Medicare benefits, as determined by the Social Security Administration, or through a cancellation, or death), and a cumulative net enrollment. The last column shows a projected cumulative net enrollment for IMC, as of the start of each month.

Table 2 shows the length of membership in IMC for active and inactive members. In December of 1985, about 60 percent of the active membership had been with IMC for more than a year, with the average length of membership being 15 months. About 6 percent of the active members had been members for more than 3 years. Members who cancelled generally did so within the first year of membership, with the average being around 7 months.

Table 3 shows the area of residence of the active membership of IMC. According to HCFA records, about 3.5 percent of the active IMC members were not Florida residents in December 1985.

Table 4 shows a distribution of IMC active members, by age. The average IMC member was 72 years old, and about 80 percent of IMC's total membership was between the ages of 60 and 80. Only about 2 percent of the membership was 90 years old, or older.

Table 1: IMC Enrollments and Disenrollments, 1982 through 1985
(20 Percent Sample File)

	New Enrollees	Deaths Cancels SSA Term	Net Enrollmt	Est. Total
08/82			1,518	7,590
09/82	110	2	1,626	8,130
10/82	190	3	1,813	9,065
11/82	327	1	2,139	10,695
12/82	290	0	2,429	12,145
01/83	395	74	2,750	13,750
02/83	199	83	2,866	14,330
03/83	194	47	3,013	15,065
04/83	234	80	3,167	15,835
05/83	231	79	3,319	16,595
06/83	268	65	3,522	17,610
07/83	175	49	3,648	18,240
08/83	202	77	3,773	18,865
09/83	134	59	3,848	19,240
10/83	139	44	3,943	19,715
11/83	624	54	4,513	22,565
12/83	468	57	4,924	24,620
01/84	2629	78	7,475	37,375
02/84	3279	219	10,535	52,675
03/84	1506	323	11,718	58,590
04/84	1356	64	13,010	65,050
05/84	1212	603	13,619	68,095
06/84	1564	404	14,779	73,895
07/84	1187	364	15,602	78,010
08/84	1057	421	16,238	81,190
09/84	1169	283	17,124	85,620
10/84	1191	329	17,986	89,930
11/84	1248	352	18,882	94,410
12/84	1215	391	19,706	98,530
01/85	1030	267	20,469	102,345
02/85	1301	313	21,457	107,285
03/85	1058	316	22,199	110,995
04/85	850	396	22,653	113,265
05/85	685	577	22,761	113,805
06/85	693	418	23,036	115,180
07/85	1033	358	23,711	118,555
08/85	747	499	23,959	119,795
09/85	564	397	24,126	120,630
10/85	706	405	24,427	122,135
11/85	1072	392	25,107	125,535
12/85	1819	370	26,556	132,780
01/86	1462	194	27,824	139,120

Table 2: Length of Membership in IMC, Active and Inactive Members

	Number of Members	
Length of Membership	Active	Inactive
1 month or less	1,471 (5.3%)	1,582 (19.6%)
2 - 12 months	9,772 (35.1%)	5,019 (62.2%)
13 - 24 months	12,743 (45.8%)	1,282 (15.9%)
25 - 36 months	2,214 (7.95%)	164 (2.0%)
37 months or more	1,633 (5.9%)	26 (0.3%)
Total	27,833	8,073

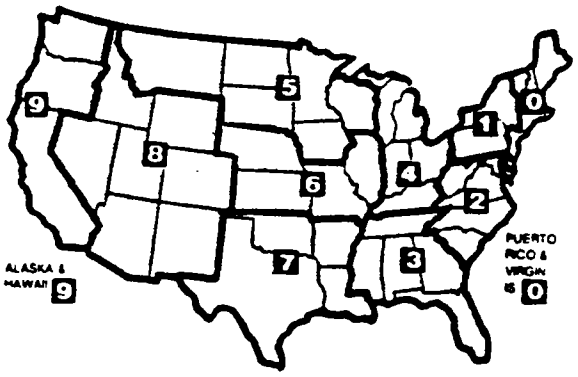


Table 3: Area of Residence (20% Sample File)

AREA	ACTIVE		INACTIVE	
(0) New England	217		188	
(1) New York-Pennsylvania	325		261	
(2) Atlantic Coast	54		44	
(3) Deep South (except Florida)	42		46	
Florida	26,849	(96.5%)	7,178	(88.9%)
(4) KY,OH,IN, And MI	200		183	
(5) North Central	35		26	
(6) Central	52		88	
(7) South Central	18		22	
(8) West	8		10	
(9) Far West	26		16	
Unknown	7		11	
Total	27,833		8,073	

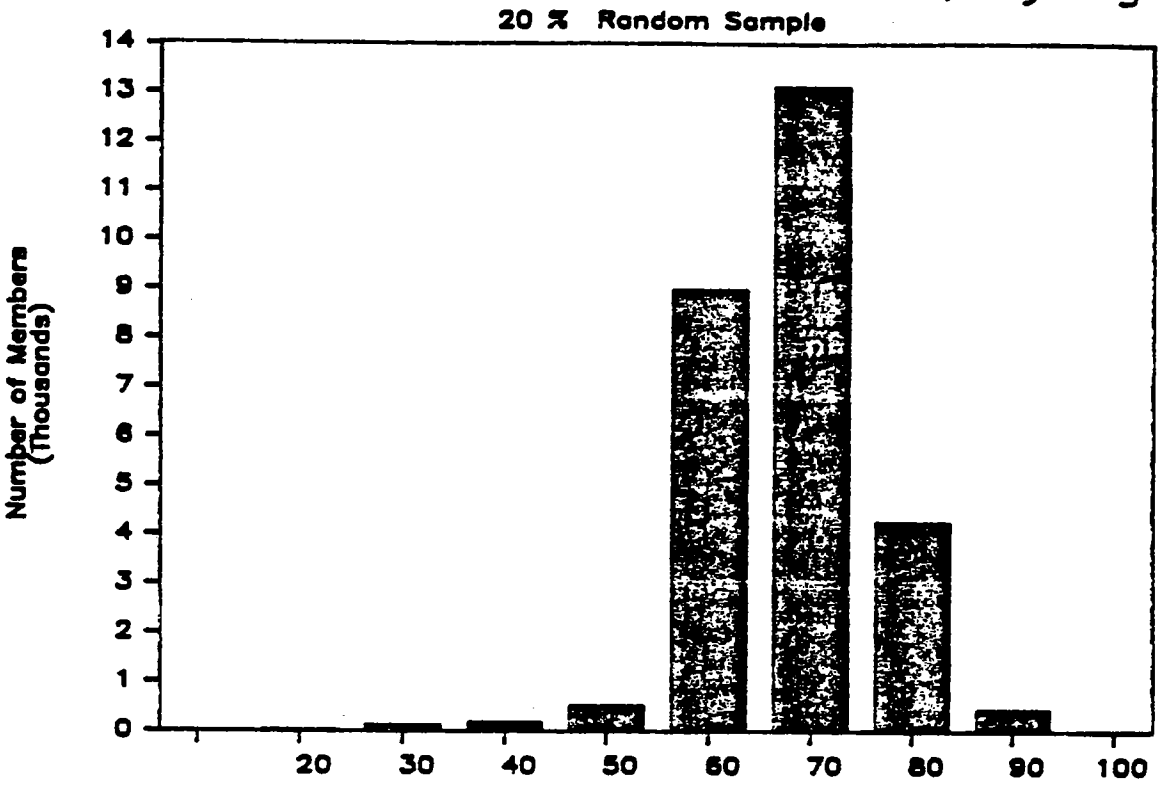


Table 4. Distribution of IMC Membership by Age Group
(20 % Random Sample)

Age Group	Active Members
20 - 29	39
30 - 39	154
40 - 49	207
50 - 59	545
60 - 69	9002
70 - 79	13150
80 - 89	4274
90 - 99	456
100 +	6

MODE is 67 (1,719 members)
MEAN is 72
RANGE is 20 - 106 years

APPENDIX B

Analysis of "Telephoned" and "Not Telephoned" Groups

A random 0.2 percent sample of current and former members of IMC (351 Medicare beneficiaries) was selected from HCFA's Group Health Plan Master file for this study. Of the original sample of 351 beneficiaries, we were able to contact 189 by telephone.

We were concerned that the results from the telephone interviews might be biased to the group that was contacted by telephone and, therefore, conducted an analysis of four known variables in both the "telephoned" and "not telephoned" groups. The results of that analysis are outlined below.

1. Proportion of males to females:

	Not Telephoned		Telephoned	
Male	74	46%	87	46%
Female	88	54%	102	54%

Chi-square=0.002 p=0.96

2. Membership status and duration:

	Not Telephoned		Telephoned	
Active, more than 1 year	98	60.5%	108	57%
Active, less than 1 year	25	15.4%	32	17%
Terminated	39	24.1%	49	26%

Chi-square=0.41 p-0.82

3. Age

	Not Telephoned		Telephoned	
Under 60	8	4.9%	5	2.7%
61-70	31	19.1%	41	21.7%
81 and over	36	22.2%	45	23.8%

Chi-square=1.67 p=0.64

4. State of residence:

	Not Telephoned		Telephoned	
Not FL residents	7	4.0%	3	1.6%
FL residents	155	96.0%	186	98.4%

Fisher's exact test p=0.11

The distributions of these variables in the "telephoned" and "not telephoned" groups are not significantly different; therefore, we do not expect that the basic results of the survey would have been different if we had interviewed all of the beneficiaries by telephone.

APPENDIX C

HCFA Comments on the OIG Draft Report:

International Medical Centers (IMC) Service Delivery Evaluation

DEPARTMENT OF HEALTH & HUMAN SERVI

Health Care Financing Administration

Memorandum

Date

From William L. Roper, M.D.
Administrator

Subject OIG Draft Report--International Medical Centers (IMC) Service Delivery Evaluation (P-12-86-00096)

To The Inspector General
Office of the Secretary

As requested, we have reviewed the draft service delivery evaluation on IMC and offer the following comments on the OIG's recommendations.

1. HCFA should send notices to all IMC enrollees (or have IMC send notices) to fully disclose what IMC does not cover, and to explain IMC's policy on out-of-plan care.

During discussions with OIG staff, we confirmed that the notices referred to in this recommendation are the lock-in notices sent only to new enrollees.

We have recently revised the lock-in notice to specify clearly that beneficiaries should contact HCFA if they believe they have not enrolled in an HMO. The notice suggests that beneficiaries should read the written material provided by the health plan to make sure they understand their appeal rights. It also explains the lock-in provision and the out-of-plan procedures.

Because of these recent revisions, we believe there is no need to modify the notice further to include a description of what is not covered. Also, all HMO/CMP marketing material, including IMC's, will be reviewed under the Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions. In addition, information given to plan members is reviewed during on-site monitoring visits. If any material is misleading or confusing, both HCFA and the State officials will require that IMC withdraw and/or revise such materials.

2. HCFA should revise the lock-in notice to advise the beneficiary that Medicare is making a monthly payment to IMC on his or her behalf.

We concur with this recommendation and will revise the lock-in notice to indicate that Medicare makes a payment each month to the HMO to cover benefits provided by the HMO.

3. HCFA should re-examine current policies for out-of-plan services for beneficiaries that spend 60 days a year outside the service area.

Managed care is the basic premise upon which the HMO concept was founded. The lock-in requirement goes hand-in-hand with the idea of managed care. The lock-in provision and how it affects out-of-plan and out-of-area coverage is stressed more than any other facet of the TEFRA risk program in all of our monitoring activities.

We do not believe that our policy needs to be changed. We recognize that the lock-in requirement may place responsibilities upon a beneficiary that he/she may not want to bear, and this is one of the primary reasons that we indicate that HMOs/CMPs are an alternative to the fee-for-service system and not necessarily the service delivery mode of choice for every beneficiary.

Thank you for the opportunity to comment on this draft report.