

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**A REVIEW OF HMO QUALITY
ASSURANCE STANDARDS REQUIRED BY
MEDICAID AGENCIES**



SEPTEMBER 1992 OEI-05-92-00110

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EXECUTIVE SUMMARY

PURPOSE

To describe health maintenance organization (HMO) quality assurance (QA) standards and the methods used by State Medicaid agencies to monitor compliance with them.

BACKGROUND

The Federal Government has encouraged the use of "managed care" or "coordinated care" systems, such as HMOs, by Medicaid agencies to curb rising expenditures in these programs. Managed care systems reduce health care expenditures through a combination of preventative health care measures and by monitoring, and to some extent controlling, the medical utilization of both provider and patient. As of June 30, 1991, approximately 5 percent of Medicaid recipients were enrolled in HMOs.

The extent to which an HMO can control utilization and costs, may mean the difference between its financial success or failure. Consequently, the incentives for these providers to limit services makes QA an essential component of managed care programs. Realizing this, Medicaid agencies mandate their contracting HMOs to perform certain QA functions to ensure that Medicaid recipients receive appropriate and good quality care.

In Fiscal Year (FY) 1992, Medicaid programs will spend an estimated \$127 billion for medical care. Almost \$72.5 billion of this amount will come from Federal matching funds. The Federal share for FY 1993 is projected to be \$84.5 billion, a 16.5 percent increase over FY 1992 outlays.

METHODOLOGY

We interviewed Medicaid officials in 24 States and the District of Columbia concerning the QA functions their contracting HMOs are required to perform. Information and documentation was obtained on how Medicaid agencies verify HMO compliance with their QA standards. Additional corroborating evidence on Medicaid agency compliance procedures was obtained from structured interviews with 28 HMOs.

FINDINGS

Medicaid agencies use structural, process and outcome QA standards to monitor contractor HMOs.

Table 1

STRUCTURAL STANDARDS	# of MEDICAID AGENCIES
Patient Education Programs	25
Access to Care *	25
Written QA Plan	23
PROCESS STANDARDS	
Credentialing	21
Individual Patient Care Data	16
Utilization Review	13
Medical Record Review	12
Reporting Physician Quality Problem Terminations	7
Clinical Practice Guidelines	6
Physician Management	3
OUTCOME STANDARDS	
Complaint/Grievance Procedures *	25
Patient Satisfaction Surveys	8
Health Outcome Monitoring and Evaluation	6

*Federal law mandates this standard

All Medicaid agencies use some form of structural standards.

- Structural standards offer an assessment of the nature of an HMO's health care resources. These resources include the facility, staff and the rules of procedure.

Medicaid agencies have carried over fee-for-service process standards to their HMO program.

- Credentialing, utilization review, medical record review and other process standards that parallel Medicaid fee-for-service experience have been readily accepted by Medicaid agencies as good managed care QA standards.

Medicaid agencies rely on complaint standards more than patient satisfaction surveys and health outcome reviews to ensure quality.

- Outcome standards provide information on how patients fared while enrolled in the HMO. Health outcome standards monitor HMO medical services over an extended period of time to ensure that they meet accepted community standards of medical practice.

Surveys of patient satisfaction with HMO operating procedures, complaints and grievances provide information on recipient experiences in accessing and using HMO services and on the soundness of HMO operations and procedures.

AGENCY COMMENTS

The Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) commented on our draft report. The HCFA felt that the draft report promoted the use of outcome QA standards over structural and

process standards and that a balance of QA standards was more desirable. They also felt that the draft report might leave some readers with the impression "...that enrollment in an HMO carries significant risk of inappropriate care."

In our response to HCFA, we agree with HCFA that a blend of QA standards is desirable. The scope of this inspection did not analyze differences in quality of care which might exist between HMO and fee-for-service providers. Consequently, this issue was not addressed in this report.

Changes to the report have been made to address comments we received from HCFA and ASPE. The complete text of their comments, and our response, can be found in Appendix C.

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INTRODUCTION

PURPOSE

To describe health maintenance organization (HMO) quality assurance (QA) standards and the methods used by State Medicaid agencies to monitor compliance with them.

BACKGROUND

Title XIX of the Social Security Act, commonly referred to as the Medicaid program, provides Federal matching funds to States* for medical care. In Fiscal Year (FY) 1992, approximately 29 million Medicaid recipients will be eligible for medical care.

State expenditures for medical care are matched by the Federal Government on the basis of a formula that measures relative per capita income in each State. Matching rates for FY 1992 are projected to range from 50 to 79.99 percent for medical assistance payments, and from 50 to 100 percent for administrative costs. In FY 1992, Medicaid programs will spend an estimated \$127 billion for medical care. Almost \$72.5 billion of this amount will come from Federal matching funds. The Federal share for FY 1993 is projected to be \$84.5 billion, an increase of 16.5 percent over FY 1992.¹

The Federal Government has encouraged the use of "managed care" or "coordinated care" systems by Medicaid programs to curb rising expenditures in State health programs. Managed care reduces health care expenditures through a combination of preventative health care measures and by monitoring, and to some extent controlling, the medical utilization of both provider and patient. In FY 1991, Medicaid agencies paid managed care entities nearly \$2 billion dollars for health care services.

A number of different managed care systems exist. This report focuses on HMOs. As of June 30, 1991, approximately 5 percent of Medicaid recipients are enrolled in HMOs. Under the President's Plan for Comprehensive Health Care Reform, which encourages the use of managed care, the number of Medicaid recipients enrolled in HMOs and other managed care systems is expected to increase.

Twenty-five States contract with HMOs to serve their Medicaid recipients. Health maintenance organizations provide services to diverse Medicaid populations; however, the vast majority of Medicaid HMOs provide medical services to families with dependent children (AFDC). Some HMOs also serve aged, blind and disabled Supplemental Security Income recipients and other medically needy Medicaid populations.²

* Throughout this report, any reference to "States" includes the District of Columbia.

The 127 HMOs providing medical care to Medicaid recipients fall into 4 primary model types:³

- (1) *Staff*, where health care services are delivered through a group practice [employees of the HMO] established by the HMO;
- (2) *Group*, where the HMO contracts with a group practice to provide health care services;
- (3) *Network*, where the HMO both provides for, and contracts with two or more group practices or physicians to provide, health care services; and,
- (4) *Individual Practice Association (IPA)*, where the HMO contracts with physicians in individual practice to provide health care services.

The extent to which an HMO can control costs related to health care, may mean the difference between its financial success or failure. Most Medicaid agencies contract with HMOs on a capitated or "at risk" basis. If the cost of providing medical services to members exceeds the capitated or fixed amount the HMO is paid, then the HMO risks losing money. The incentives for these HMOs and the providers within their network to limit services makes QA an essential component of managed care programs.

Simply defined, QA is an ongoing process for evaluating and improving the medical and other health related services. It is a rapidly evolving and complex area; consequently, "Standards to measure effectively the impact of care on [patient] outcome or to evaluate the quality of managed care itself are not well developed..."⁴ Even in the fee-for-service arena, which has been around for more than 20 years, not much is known about the efficacy of QA. In both fee-for-service and HMO environments, Medicaid and other agencies have developed QA programs to ensure that patients receive appropriate and good quality care.

METHODOLOGY

This study is limited to HMOs. It describes QA measures used by State Medicaid agencies to monitor HMOs. Medicaid fee-for-service and other medical payment options, such as prepaid health plans, were not reviewed. This study focuses on State Medicaid agency QA requirements and monitoring. Health maintenance organizations are subject to reviews by other governmental and private agencies. They also conduct their own internal QA assessments. This inspection did not describe HMO internal QA standards or QA standards imposed on HMOs by other governmental or private agencies.

We conducted structured interviews with all 25 Medicaid agencies that contract with HMOs to provide medical care. The remaining Medicaid agencies did not contract with HMOs, at the time of our inspection, and were not contacted.

The 25 Medicaid agencies contacted for this inspection were located in the following States: California, Colorado, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Washington and Wisconsin.

Visits were made to 16 States, the remaining 9 were contacted by telephone. Geographic location, HMO characteristics, HMO population and other factors were used to select the 16 States for onsite visits. Once a State had been selected, the HMOs with Medicaid contracts were contacted and asked to participate in this study. In some States, the Medicaid agency had a single contracting HMO; in others, multiple HMOs held contracts to provide services to Medicaid recipients. In States with multiple HMO contracts, we tried to select HMOs with different characteristics. The HMOs participating in this study were not selected at random; participation was entirely voluntary. The HMOs selected and their characteristics can be found in Appendix A.

Using a structured interview guide, we discussed QA with 28 of the 127 HMOs serving Medicaid recipients. These discussions often included the Chief Executive Officer of the HMO, the medical director, marketing representative and QA coordinator.

We compiled our list of QA standards from three sources:

- The National Committee for Quality Assurance's QA standards dated June 27, 1991.
- The National Association of HMO Regulators (NAHMOR)/National Association of Insurance Commissioners' (NAIC) Recommended Operational Requirements for HMO QA Programs, adopted by the NAIC/NAHMOR Joint Task Force in December 1988.

- The HCFA Office of Prepaid Health Care's QA standards for HMOs and Competitive Medical Plans contracting with the Medicare program dated November 1989.

We identified 13 standards that encompassed all of the standards endorsed by these entities. Our list was not all inclusive. The detail of the standards put forth by these entities is extensive, and we did not attempt to address all of the nuances in this inspection.

Medicaid agencies were asked to identify, from our list of QA standards, the standards contracting HMOs were required to have in place. They were also asked how they verified HMO compliance with required standards.

The HMOs were asked to identify which of our QA standards they had in place. They were also asked to identify which QA standards were required as part of their contract with the State Medicaid agency. Like Medicaid agency respondents, HMO respondents were asked how the agency verified compliance. Interview responses were compared. Discrepancies in responses were resolved by reviewing documents and/or recontacting respondents.

The final step in our analysis was to classify each of our QA standards as either structural, process or outcome. An argument can be made for classifying a standard in more than one category; we classified them into a single category using the following criteria:

- Standards that provided an assessment of HMO facilities, staff, resources and rules of procedure were classified as structural standards.⁵
- Standards that provided data and information on adherence to HMO internal policies, resource consumption and choice of therapies at a fixed point in time were classified as process standards.⁶
- Standards that provided Medicaid agencies with information on the net results of HMO policies, practices, procedures and quality assurance measures were classified as outcome standards.⁷

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

MEDICAID AGENCIES USE STRUCTURAL, PROCESS AND OUTCOME QA STANDARDS TO MONITOR CONTRACTOR HMOs.

Table 1

STRUCTURAL STANDARDS	# of MEDICAID AGENCIES
Patient Education Programs	25
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OUTCOME STANDARDS	
Complaint/Grievance Procedures *	25
Patient Satisfaction Surveys	8
Health Outcome Monitoring and Evaluation	6

*Federal law mandates this standard

Health maintenance organizations enter into contracts with Medicaid agencies to provide health care and related services to Medicaid recipients. One function of the Medicaid agency is to ensure that their recipients receive good quality care in these HMOs. To accomplish this goal, Medicaid agencies have adopted a number of QA standards. (See Appendix B for HMO QA standards required by each State.)

Quality assurance standards are interactive and could fall into more than one of three categories. For example, a requirement to credential physicians could be considered a structural standard, while one addressing how to credential physicians could be a process standard. In this report, we have divided QA standards into three categories: structural, process and outcome.

Structural standards provide an assessment of the nature of an HMO's health care resources; its facility, staff and the rules of procedure.⁸

Process standards assess the intermediate products of care such as utilization rate, choice of therapies and adherence to, and effectiveness of, procedures.⁹ Process standards provide data and information on adherence to HMO internal policies and procedures. They provide data for comparing resource consumption by the HMO's affiliated physicians and hospitals.

Process medical record reviews also provide information about the quality and appropriateness of medical care given to a patient at a specific point in time. These narrowly focused medical record reviews may fail to detect underutilization of HMO services or the benefits of HMO preventative health care and patient counseling.¹⁰

Outcome standards focus on the net results of HMO care over an extended period of time. They also focus on the health of the HMO itself. Surveys of patient satisfaction with HMO operating procedures, complaints and grievances and longitudinal assessments of medical care, all provide information on how patients fared when enrolled in HMOs. Outcome standards assess the clinical and nonclinical components of HMO care which directly impact on patients.

Outcome standards must always be balanced with measures of structure and process to ensure high quality medical care. Structural and process standards are widely used by HMOs, regardless of government mandates, because they are inherent in HMO philosophy and good business practices.^{11 12 13}

ALL MEDICAID AGENCIES USE SOME FORM OF STRUCTURAL STANDARDS.

Structural standards (see Table 1) offer an assessment of the nature of an HMO's health care resources. These resources include the facility, staff and the rules of procedure.¹⁴ Some QA proponents feel structural standards "... are appropriate objects of scrutiny only to the extent that they are demonstrably related to valued outcomes."¹⁵ For example, evaluating prenatal care patient education programs to determine their impact on low birth weights is appropriate because it measures the effect or outcome of the education program. Simply reviewing educational materials on prenatal care without evaluating the effect on the patient does not assess if the program is effective and does not provide any information that might be used to improve the program.

- ▶ *All Medicaid HMOs are required to develop a written QA plan.*

A QA plan serves as a blueprint for an HMO's entire QA activities. It is a descriptive outline of an HMO's QA objectives. Implementation, monitoring and evaluation of the plan is designed to identify deficiencies in HMO operations and quality of care, and promote corrective action and improvements.¹⁶

Twenty-three Medicaid agencies require their HMOs to develop a written QA plan. Two Medicaid agencies do not specifically stipulate this standard in their HMO contracts, believing it to be unnecessary as another governmental body requires it. In one State, it is the State Department of Public Health. In the other, the contracting HMO meets Federal standards.

Many Medicaid agencies do not use the QA plans developed by HMOs as a guide to evaluate the HMO's total QA program. Most (17 of 25) Medicaid agencies review the written QA plans of their HMO contractors during the contracting process. The agency Medical Director or an RN reads the plan to determine if QA standards are described, and if appropriate processes are in place to implement these standards. Of the 17 Medicaid agencies that review the HMO QA plan, at least half do not keep the

plan on file. Some Medicaid agencies, while requiring the QA plan to be on file, do not review it.

In five States, another agency or organization in addition to, or in place of, the Medicaid agency reviews the HMO's QA plan. For example, the Department of Public Health, a Peer Review Organization (PRO) or State Department of Insurance review the plan. Coordination among these agencies varies. Several HMOs complained that the involvement of multiple oversight agencies results in duplicate efforts.

Nineteen Medicaid agencies require their HMO contractors to have an active QA committee to implement and oversee the performance of the QA functions outlined in the HMO's QA plan. All of these Medicaid agencies review minutes from the HMO's QA committee meetings to verify the committee's activities. Three Medicaid agencies have employees attend and participate in HMO QA meetings.

- ▶ *All Medicaid agencies are actively involved in HMO patient education programs, some working closely with their HMOs to develop educational materials on patient benefits, rights and responsibilities.*

Patient education programs disseminate information on patient rights and responsibilities, benefits, charges, access to care and scheduling of services. This information is conveyed to Medicaid recipients primarily through HMO marketing materials.

Federal law (42 CFR Section 434.36) requires Medicaid contracting HMOs to "...assure the agency that marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the agency." States have responsibility for monitoring adherence to these standards. Some States have developed additional standards applicable to marketing materials. All of the Medicaid agencies we interviewed were actively involved in reviewing their HMOs' marketing materials.

Some Medicaid agencies work closely with their HMOs to develop patient education materials. Other agencies simply advise HMOs about the content of their patient education materials. Almost all Medicaid agencies review all marketing or handbook material the HMO supplies to Medicaid recipients. Some Medicaid agencies formally authorize the release of educational materials and any changes to the materials to further ensure the correctness of information HMOs disseminate. Those Medicaid agencies that are not involved in patient education rely on another State agency to review and approve educational materials.

- ▶ *All HMOs are required to provide access to care and Medicaid agencies use a variety of methods to verify adherence to policy.*

Federal and State laws require all HMOs providing emergency medical services to ensure recipient access to care at all times.¹⁷ All but 1 of the 25 Medicaid agencies require HMOs to ensure recipient access to health care services. The Medicaid agency that does not require this standard, does not do so because it is already required by Federal law governing HMOs.

Some Medicaid agencies use a variety of one or more approaches to verify compliance. More than half (14) of the Medicaid agencies monitor grievances and complaints on access. Eight agencies review HMO internal procedures and guidelines regarding access. Eleven take a more aggressive approach and use medical chart reviews or random calls to HMO clinics, physicians and answering services to ensure adherence to HMO policy on access to care. One agency spot checks notices posted in clinics on how to obtain after-hour services. Two review after-hour and transportation logs. Another uses recipient surveys. Four Medicaid agencies maintain a 24-hour toll free hotline for Medicaid HMO recipients, should they experience difficulty obtaining services.

MEDICAID AGENCIES HAVE CARRIED OVER FEE-FOR-SERVICE PROCESS STANDARDS TO THEIR HMO PROGRAM.

Process standards assess the intermediate products of care such as utilization rate, choice of therapies and effectiveness of procedures.¹⁸ This category of standards is widely used by HMOs to: (1) minimize exposure from unqualified individuals, (2) monitor resource consumption, (3) assess adherence to HMO accepted standards of practice, and (4) manage their care network and provider behavior.

Process standards (see Table 1) are usually embraced by HMOs regardless of Medicaid agency mandates because they are perceived to be good business practices. They are perceived to be good tools for overseeing day to day business operations.

Most process standards find their roots in the fee-for-service system. Credentialing, patient care data, utilization and medical record reviews have been the cornerstone for assessing QA in fee-for-service for decades. Medicaid agency familiarity with these processes made them prime candidates for acceptance into most Medicaid agencies' managed care QA programs. Less familiar standards, such as clinical practice guidelines and the management of physician conduct are somewhat unique to managed care and have not been as easily assimilated in Medicaid QA programs.

Process standards are necessary to HMO QA as they minimize risk, provide indications of potential problems and enable corrective action. However, QA standards addressing credentials, data, practice guidelines and physician management do not, in themselves, *measure* the quality of care a patient received. Medical record

reviews do provide an indication of the quality of care provided on a given day or over a short period of time but are limited in their ability to provide sufficient information on which to judge HMO practices.

- ▶ *Twenty-one Medicaid agencies require HMOs to credential; most HMOs meet or exceed mandated requirements.*

Credential verification is one method used to minimize the risk of inadequate or harmful care to Medicaid patients from incompetent providers. This process often involves the Medicaid agency and other myriad organizations, accrediting bodies and providers.

Most (21) Medicaid agencies require their HMOs to verify that the physicians and other health care professionals they employ are qualified and properly credentialed. Four Medicaid agencies rely on another State entity to verify credentials and do not require their HMOs to independently credential their providers. In two cases, the HMO is only required to verify that physicians in their network hold a current, valid license to practice medicine.

We found that 23 of 28 HMOs had credential verification processes in place that met or exceeded Medicaid agency mandates. Physician credentialing is a good business practice. Court decisions have held HMOs responsible for the actions of their contracted physicians.¹⁹ In addition to offering a measure of liability protection, physician credentialing allows HMOs to select physicians whose practice style reflects the HMO's philosophy and objectives.

Independent confirmation of HMO credentialing results by Medicaid agencies is practically nonexistent. Four agencies conduct random samples of HMO physician files to assess HMO adherence to credentialing guidelines. Most Medicaid agency credential verification consists of a check on the licensure or Medicaid participating status of providers. Six agencies review credentialing methodology but do not verify whether the HMO adheres to its guidelines.

As in other areas, Medicaid agencies often do not verify or enforce credential verification. Some Medicaid respondents knew or assumed that another State entity verified the credentials of HMO physicians. However, some of these respondents were unsure exactly which State entity might actually perform this function, or what the other State entity's credential verification process encompassed.

- ▶ *Patient care data received from HMOs often does not meet Medicaid agency expectations.*

Patient care data is statistical information collected by HMOs from patients' medical records, contract providers and patient surveys. It enables HMOs to assess patient use of medical services, patient satisfaction and the nature of services provided by the HMO's affiliated physicians and hospitals.²⁰

Patient care data is often used during utilization review to eliminate unnecessary care and services; thereby, controlling costs and improving quality.²¹ Utilization review programs employed by HMOs include: (1) pre-authorization of specialty services; (2) mandatory second opinion; (3) concurrent review of all hospital admissions and discharge planning; (4) high cost case management; (5) pre-negotiated specialty, referral contracts; and, (6) education of members and providers on utilization of services.²²

Patient care data collected by HMOs is customized to fit individual HMO needs. While the content of the information HMOs collect is similar, each HMO establishes their own criteria for data collection. Some HMOs collect detailed claims information similar to that collected under the fee-for-service system; others collect aggregate data from their contracted hospitals, physicians, laboratories, pharmacies and other suppliers and have little or no patient specific data. The data collected by HMOs is usually dictated by their largest subscriber since most HMOs are unable to comply with all their subscribers' data requests.²³

Sixteen of 25 Medicaid agencies require HMOs to collect individual patient care data and 13 require HMOs to conduct internal utilization review. Medicaid agencies that require HMOs to provide individual patient care data often find that the information does not meet their expectations. For example, some agencies expect data from HMOs to mirror their fee-for-service claims data, this may not be feasible given the variety of HMO business arrangements. Medicaid agencies willing to work with HMO data have better compliance. A similar problem appears to exist in the area of HMO utilization review. Medicaid agencies that attempt to impose fee-for-service utilization review methodologies are less successful in obtaining useful HMO data than those who adopt HMO methodologies.

Most Medicaid agencies are not familiar with the kinds of data HMOs collect. Until recently, data collection among HMOs has primarily focused on inpatient hospital services. Service specific encounter data is not common in capitated managed care systems that have no need to maintain detailed claims information.²⁴ On the other hand, HMOs that reimburse their contract physicians on a fee-for-service basis can reasonably be expected to collect much more detailed patient care information.

- ▶ *All Medicaid agencies conduct episodic medical record reviews; 12 also require contracting HMOs to conduct their own internal medical record reviews.*

Medical records are considered to be the best source of information on the technical aspects of care.²⁵ Medical record reviews have traditionally been Medicaid's primary source of information for QA.²⁶ Medical record reviews and the methodologies used to conduct them are steeped in the history of the fee-for-service system. Traditional medical record reviews examine the type and quality of care a patient received on a particular day. They are episodic rather than longitudinal in scope, consisting of a review of a single health care event. In the HMO environment focusing on the appropriateness and quality of care surrounding a single health care event may fail to

detect underutilization of services or recognize the benefits of HMO preventative health care and patient counseling.²⁷

Federal law requires Medicaid agencies to conduct an independent, external review of the quality of services furnished by HMO contractors. This law requires that States use a PRO or a private accreditation body to perform the review.²⁸ All of the Medicaid agencies we interviewed are in compliance with this statutory requirement and contract with either PROs or private accreditation bodies to examine HMO medical records to assess the quality of medical care.

Medical record reviews may occur quarterly, bi-annually, or annually. Reviews may be traditional medical record examinations of the care provided surrounding a particular medical episode or target specific Medicaid services such as immunizations or groups of recipients such as pregnant women. If the Medicaid population in an HMO is very small, all Medicaid recipient medical records may be reviewed. More often, the number of recipients enrolled in an HMO limits the number of reviews to 2 to 10 percent of the HMO's Medicaid population.

Some Medicaid agencies, in addition to the independent, external review required by Federal law, performed their own medical record reviews to assess the quality of contracting HMO services. Twelve also require their HMO contractors to conduct their own independent, internal medical record reviews and to report their findings to the Medicaid agency.

Even when no requirement exists for HMOs to conduct their own internal medical record reviews, HMO respondents indicated that they do so because these reviews are a good business practice. They help the HMO detect unbundling of services, upcoding of services and provide information on the use of services by HMO fee-for-service subcontractors.²⁹ Medical record reviews can also lead to the early detection of aberrant physician practice patterns.

Seven of the 12 Medicaid agencies rely on medical record reviews to verify HMO compliance, but only one audits a sample of the medical records actually reviewed by the HMO to verify its findings. Three agencies review HMO reports to assess the nature, completeness and accuracy of HMO medical reviews. Two do not verify HMO compliance with this QA requirement.

Health maintenance organizations are subject to numerous medical record reviews by multiple State and Federal agencies, independent accrediting organizations and contract subscribers. Duplicative, uncoordinated reviews often result in conflicting findings. One HMO received an exemplary rating on its medical records from one governmental body while another found the same records "wanting."

- ▶ *Few (6) Medicaid agencies require use of clinical practice guidelines establishing standards of care.*

In managed care systems clinical practice guidelines can play a vital role in ensuring good quality medical care. Practice guidelines are thought to promote the use of best practices in medical care. They provide "...greater consistency of care...[and reduced] risk of harm [to the patient] resulting from omission."³⁰

The involvement of para-professionals, financial incentives and other factors unique to managed care provide the foundation for advocating the development and use of clinical practice guidelines by HMOs. Clinical practice guidelines are usually developed for high risk conditions such as chronic heart disease, substance abuse, C-sections and hypertension. ~

Most (19 out of 25) Medicaid agencies do not require HMOs to develop or use clinical practice guidelines. The six Medicaid agencies that require their HMOs to develop and use clinical practice guidelines vary considerably in their approach. In two cases the Medicaid agency, HMO administrative staff and HMO providers have worked together to establish practice guidelines. One Medicaid agency has developed their own guidelines for specific encounters. This agency requires all of their contracting HMOs to use these guidelines in addition to any HMO developed guidelines. The three remaining agencies review proposed guidelines to ensure they meet community standards of care but are not involved in the actual development of guidelines.

Despite lack of a Medicaid agency mandate, more than 70 percent of HMOs we reviewed have developed one or more practice guidelines. Within HMOs, consensus groups of physicians develop agreed-upon standards of practice, which are then used to evaluate their peers and identify potential quality of care deficiencies.

Medicaid agencies that mandate clinical practice guidelines verify provider adherence to guidelines during the medical record review process.

- ▶ *Only three Medicaid agencies require HMOs to manage physician behavior.*

Physicians are the pivotal decisionmakers in HMOs.³¹ Their practice patterns can make the difference between an HMO's financial success or failure.³² Because physicians play such a critical role, HMOs provide financial and other incentives to manage their behavior.³³

The HMOs manage physician behavior by: (1) selecting physicians whose practice style reflects the HMO's philosophy and objectives, (2) providing physician education and feedback on practice patterns in comparison with other HMO physicians, and (3) offering financial incentives directly impacted by the physician's practice patterns.³⁴ In a 1988 survey of its membership, Group Health Association of America (GHAA) reported that "...73 percent of all HMOs have capitation

arrangements with physicians, and nearly 40 percent withhold a proportion of the physicians' fees or capitation, putting them at financial risk for poor financial or utilization performance of the HMO."³⁵

Health maintenance organizations use data collected by their systems to identify physicians whose practice patterns differ from their peers. This data, coupled with information derived from medical record reviews, is used to educate physicians who do not provide services within expected practice parameters. Depending on the nature of the findings, the HMO may decide to: (1) educate the physician on the HMO's policy and standards of practice, (2) provide remedial training to improve the physician's technical skills, (3) discipline the physician, or (4) terminate the physician's contract.

Of the 25 Medicaid agencies that contract with HMOs, only 3 have QA standards which directly address physician management. Medicaid agencies are not involved in physician management because they believe it is inherent in the HMO philosophy and a good HMO business practice.

Seven agencies require HMOs to report to them, or other appropriate authorities, serious quality problems resulting in a physician's suspension or termination. And four agencies require HMOs to identify providers no longer affiliated with the HMO, but do not require the HMO to provide a reason for the provider's termination.

MEDICAID AGENCIES RELY ON COMPLAINT STANDARDS MORE THAN PATIENT SATISFACTION SURVEYS AND HEALTH OUTCOME REVIEWS TO ENSURE QUALITY.

Outcome standards (see Table 1) provide information on how patients fared while enrolled in the HMO. They assess not only the end products of medical care such as patient health status but also the soundness of HMO operations and procedures. Surveys of patient satisfaction with HMO operating procedures, complaints and grievances provide information on recipient experience in accessing and using HMO services. Health outcome medical reviews** examine the entire spectrum of medical care an HMO has provided to a recipient. These outcome medical reviews differ from episodic medical record reviews because they take into consideration all of the medical care, preventative measures and education a recipient received from the HMO.

** The term health outcomes is widely used by government agencies and the private sector. The precise meaning of health outcome differs depending on what product or use the entity has in mind. In this report, the term health outcome reviews means a longitudinal assessment of the medical record(s) of an HMO patient to determine whether due care was exercised in providing medical services. Were services under used, were preventative measures taken, were the preventative and medical interventions appropriate and within accepted community standards of care? As used in this report, our definition of health outcome reviews is not related to the development of clinical information data bases that rank post-treatment health status, provide treatment options or other applications.

- ▶ *Although HMOs are required to resolve patient complaints and grievances, most Medicaid agencies rely on HMO reports to verify compliance.*

All 25 Medicaid agencies require their HMOs to have a process for resolving patient complaints and grievances. Federal law requires an internal grievance procedure which: "(a) Is approved in writing by the [Medicaid] agency; (b) Provides for prompt resolution; and (c) Assures the participation of individuals with authority to require corrective action."³⁶

Total reliance on HMOs to handle the complaints and grievances may leave the Medicaid agency vulnerable and put recipients at risk. In the HMO environment, complaints and grievances about the HMO can originate from many sources. Physicians and other HMO subcontractors, patients and others may complain about HMO practices and procedures. Complaints may provide early warning about the financial practices and stability of an HMO. Complaints may reveal problems with access to services and patterns indicative of poor care.

Fourteen Medicaid agencies reduce the risk associated with HMOs assessing their own performance by performing periodic reviews of HMO complaint files. Some Medicaid agencies sample complaint files, while others review all files to ensure recipient complaints have been properly addressed. Reviews are conducted onsite, or through information provided by the HMO.

Five Medicaid agencies operate their own complaint and grievance units. These agencies believe that their direct involvement in the resolution of recipient complaints provides them with greater insight of their HMOs' QA.

- ▶ *Eight Medicaid agencies require HMOs to conduct patient satisfaction surveys. Seven conduct their own surveys to assess, firsthand, recipient satisfaction.*

Medicaid agencies use surveys to assess recipient satisfaction with HMO services. Twenty-six of the 28 HMOs we interviewed conduct satisfaction surveys regardless of agency mandate. The surveys are intended to provide information about problems patients encounter in scheduling and securing medical services. Surveys are also used to elicit patient perceptions of facilities, providers and care.

Eight of 25 Medicaid agencies require their HMOs to conduct patient satisfaction surveys. These surveys are conducted by mail, telephone or in person. Some of these agencies are actively involved with their HMOs in the design and conduct of satisfaction surveys. Others leave survey design and collection methods to the discretion of the HMO. As with complaints and grievances, allowing HMOs to assess their own patient satisfaction may leave the Medicaid agency vulnerable, unless the agency is integrally involved in all phases of the survey. Sampling methodologies leading to an underrepresentation of Medicaid recipients and HMO self-reporting could bias reporting.

Seven Medicaid agencies conduct their own surveys. They believe they are getting a clearer picture of what is occurring in the Medicaid population, because they are obtaining information firsthand from the recipient. They believe this to be particularly true where Medicaid recipients represent a small percentage of HMO enrollment. These agencies believe their involvement in satisfaction surveys enables them to take an active role in corrective actions.

- ▶ *Medicaid agencies and HMOs find the term "health outcomes" ambiguous, sometimes interpreting it to mean utilization review or medical record review.*

Health outcome monitoring and evaluation is a new and evolving, complex QA process which focuses on the net results of care. As used in this report, health outcome monitoring and evaluation involves a longitudinal review of an HMO patient's medical record to determine if the care that recipient received met community standards.

Because they examine all of the medical care a recipient received while enrolled in an HMO, health outcome reviews take more time and resources than do medical record reviews. Medical record reviews are usually episodic - they examine the application of medical knowledge and treatment surrounding a specific medical episode. Health outcome reviews look at the care provided prior to, during and after a specific health care event. Consequently, fewer health outcome medical reviews can be conducted annually.

Proponents think that health outcome reviews are more likely to detect the benefits of preventative health maintenance and patient counseling, underutilization of services and poor quality of care in HMOs than would episodic medical record reviews.³⁷ The following example illustrates how health outcome medical record reviews differ from episodic medical reviews. An episodic medical review may determine that a child was seen and properly treated for measles. It may not determine if the child was ever immunized for measles. Health outcome medical record reviews would not only determine that the child was properly treated for measles but also whether the HMO had vaccinated the child to prevent measles.

Medicaid agency and HMO respondents found the term "health outcome review" ambiguous, sometimes interpreting it to mean utilization review or episodic medical record reviews. Based on their own interpretation of the term, 6 of the 25 Medicaid agencies indicated that they required their HMOs to monitor and evaluate the health outcomes of their Medicaid patients. Medicaid agencies verify compliance by reviewing medical records or patient care data.

One agency respondent doubted that any Medicaid agency or HMO was conducting health outcome reviews involving the examination of the care a recipient received from an HMO over an extended period of time. The term health outcome review was mentioned frequently in HMO QA literature and proposed QA standards. Despite

what appears to be widespread use of the term, considerable differences apparently exist in defining what constitutes a health outcome review.

AGENCY COMMENTS

We wish to thank both the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) for commenting on the draft report.

The HCFA felt that the draft report promoted the use of outcome QA standards over structural and process standards and that a balance of QA standards was more desirable. They also felt that the draft report might leave some readers with the impression "...that enrollment in an HMO carries significant risk of inappropriate care."

In our response to HCFA, we agree with HCFA that a blend of QA standards is desirable. The scope of this inspection did not analyze differences in quality of care which might exist between HMO and fee-for-service providers. Consequently, this issue was not addressed in this report.

Changes to the report have been made to address comments we received from HCFA and ASPE. The complete text of their comments, and our response, can be found in Appendix C.

APPENDIX A

CHARACTERISTICS OF HMO RESPONDENTS

CHARACTERISTICS OF HMO RESPONDENTS^a

HEALTH MAINTENANCE ORGANIZATIONS	FQ — SQ	MODEL TYPE(S)	WAIVER/ ENROLLMENT TYPE	TOTAL ENROLLEES as of 12/31/91	MEDICAID ENROLLEES as of 6/30/91	
HMO1	FQ	Staff	N/A	20,635	8,951	(43%)
HMO2	SQ	IPA	75/25	13,500	10,907	(81%)
HMO3	SQ	UNKNOWN	75/25	UNKNOWN	36,958	
HMO4	SQ	IPA, Group	N/A	86,000	19,392	(23%)
HMO5	SQ	IPA	1915(b)/MA	197,959	8,304	(4%)
HMO6	FQ	Network	N/A	199,244	64,007	(32%)
HMO7	SQ	IPA, Staff	N/A	57,380	35,280	(61%)
HMO8	FQ	IPA, Network	N/A	90,835	1,065	(1%)
HMO9	FQ	Staff, Group	N/A	509,000	11,674	(2%)
HMO10	FQ	IPA	N/A	151,750	2,224	(1%)
HMO11	SQ	Network	N/A	17,110	7,191	(42%)
HMO12	SQ	IPA	N/A	122,281	28,094	(23%)
HMO13	FQ	IPA, Staff	75/25	85,252	64,635	(76%)
HMO14	FQ	IPA	N/A	92,262	45,054	(49%)
HMO15	FQ	IPA, Network	N/A	17,143	11,665	(68%)
HMO16	SQ	IPA	1115/M	525,000	35,522	(7%)
HMO17	SQ	IPA	1115/M	10,290	5,966	(58%)
HMO18	FQ	IPA	1915(b)/M	40,911	5,909 ^b	(14%)
HMO19	SQ	UNKNOWN	1915(b)/M	UNKNOWN	12,225	
HMO20	FQ	Group	N/A	154,736	19	(0.01%)
HMO21	SQ	Group	N/A	48,938	9,011	(18%)
HMO22	SQ	IPA	N/A	123,000	628	(0.5%)
HMO23	SQ	Staff	N/A	UNKNOWN	3,072	
HMO24	SQ	IPA	N/A	16,688	8,531	(51%)
HMO25	SQ	IPA	N/A	156,843	30,828	(20%)
HMO26	SQ	Staff, Network	N/A	471,995	2,021	(0.4%)
HMO27	SQ	Network	75/25, 1915(b)/M	18,900	4,413	(40%)
HMO28	SQ	IPA	1915(b)/M	151,476	47,521	(31%)

SOURCES:

- (1) "Report on Medicaid Managed Care Enrollment," DHHS/HCF/MEDICAID BUREAU, June 30, 1990.
- (2) "Medicaid Coordinated Care Enrollment Report," DHHS/HCF/MEDICAID BUREAU, June 30, 1991.
- (3) "1992 National Directory of HMOs," GHAA, Washington, DC.
- (4) Respondents. In a few cases information is "UNKNOWN." Respondents were unable to provide this information prior to the finalization of this report.

^a Clarification of the terms used in Appendix A can be found on page A-3.

^b Data as of 6/30/90.

TERMS USED IN APPENDIX A

- Federally Qualified:** An HMO is federally qualified (FQ) if it meets certain health service requirements {described in Sec. 1301(b) of the Public Health Service Act, 42 U.S.C. § 300e(6)} and certain organizational and operational requirements {described in Sec. 1301(c) of the Public Health Service Act, 42 U.S.C. § 300e(c)}.
- State Qualified:** Medicaid contracting HMOs that are not federally qualified must be State qualified (SQ). They must meet the HMO requirements outlined in the State Plan (Section 1902 of the Social Security Act); unless an exemption has been approved by HCFA under waiver.
- 1115/M Waiver:** Under Section 1115, HMOs operate as managed care demonstration programs with the option of having any section of the Social Security Act waived. An 1115/M waiver provides for mandatory enrollment of Medicaid recipients in the HMO.
- 1915(b)/M Waiver:** A 1915(b)/M waiver provides for mandatory enrollment of Medicaid recipients in an HMO or PHP or, in the case of a Health Insuring Organization, a choice of primary care physicians.
- 1915(b)/MA Waiver:** 1915(b)/MA waiver provides for mandatory alternative enrollment. It is used in situations where the Medicaid recipient is required to participate under a State's primary care case management (PCCM) program but is allowed to join a Medicaid contracting HMO or PHP as an alternative.
- 75/25 Waiver:** Section 1903(m)(2)(A)(ii) of the Social Security Act requires that HMO enrollment composition be no more than 75 percent Medicare and/or Medicaid eligible enrollees. An HMO may obtain a waiver to this requirement to increase the percentage of its Medicare and/or Medicaid enrollees.
- Staff Model:** Health care services are delivered through a group practice [employees of the HMO] established by the HMO.
- Group Model:** The HMO contracts with a group practice to provide health care services.
- Network Model:** The HMO both provides for, and contracts with two or more group practices or physicians to provide, health care services.
- IPA Model:** The HMO contracts with physicians in individual practice to provide health care services.

APPENDIX B

STATE BY STATE COMPARISON OF QA STANDARDS FOR MEDICAID HMOs

A STATE BY STATE COMPARISON OF QA STANDARDS FOR MEDICAID HMOs

STATE	CA	CO	DC	FL	HI	IA	IL	IN	MA	MD	MI	MN	MO	NC	NH	NJ	NY	OH	OR	PA	RI	TN	UT	WA	WI
Grievance Procedures *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Patient Education Programs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Access to Care *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Written QA Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Credentialing	X	X	X	X		X	X	X	X	X	X	X		X		X	X	X	X	X	X	X	X		X
Individual Patient Care Data		X		X		X	X	X	X			X	X		X	X	X	X	X			X		X	X
Utilization Review	X	X				X	X	X		X	X				X	X		X		X		X		X	
Medical Record Review	X		X			X	X		X	X		X					X	X	X	X					X
Patient Surveys			X			X			X	X		X				X	X	X							
Reporting Physician Quality Problem Terminations	X		X			X	X		X	X									X						
Clinical Practice Guidelines						X	X		X	X								X		X					
Health Outcome Monitoring & Evaluation							X	X									X	X				X			X
Physician Management						X			X										X						

* Federal law mandates this standard.

APPENDIX C

AGENCY COMMENTS



JUN 29 1992

Memorandum

Date *William Toby, Jr.*
William Toby, Jr.
From Acting Administrator

Subject OIG Draft Report: "Quality Assurance in Medicaid HMOs,"
OEI-05-92-00110

To Inspector General
Office of the Secretary

We have reviewed the subject draft report which examines the Quality Assurance (QA) standards used by Medicaid agencies to minimize the risk of inappropriate medical care in Health Maintenance Organizations (HMOs). The President's Plan for Comprehensive Health Care Reform encourages the use of HMOs as part of coordinated care initiatives.

OIG interviewed 25 Medicaid agencies that contract with HMOs, and conducted onsite interviews at the HMOs in 16 of these 25 States. OIG identified 13 basic QA assessment standards that encompassed almost all of the various standards employed at the sampled HMOs. OIG noted that all Medicaid agencies require use of 4 or more of the basic 13 standards, and all were found to employ some form of structural standards. "Structural standards" as defined in this report "provide an assessment of the nature of an HMO's health care resources: its facility, staff and the rules of procedure."

In some cases, Medicaid agencies were found to have continued to apply fee-for-service process standards in their QA reviews of HMOs, though such standards may not have been appropriate yardsticks for measuring quality in coordinated care settings. These agencies were also found to rely more on complaints than patient satisfaction surveys or health outcome reviews to ensure quality. To some extent, this practice occurred because both Medicaid agencies and HMOs found the term "health outcomes" ambiguous. Often, the determination of patient outcome was accomplished solely through self-assessment by the HMOs.

Although this report is descriptive in nature, and contains no direct recommendations for the Health Care Financing Administration, we are providing general and technical comments. These comments address both the content and format of this study.

Page 2 - Inspector General

QA is a complex area that is rapidly evolving. We were impressed by the energy and commitment obvious in this particular QA investigation. We appreciate the difficulty of the task undertaken by OIG staff in this evaluation, and thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our comments on the report at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on OIG Draft Report: "Quality Assurance
in Medicaid HMOs," OEI-05-92-00110

General Comments/Observations

Title and Purpose. The title of this report, "Quality Assurance (QA) in Medicaid HMOs," implies that the report will address how QA is conducted by Health Maintenance Organizations (HMOs) contracting with Medicaid. Instead, its subject matter is limited to a descriptive summary of how State agencies monitor HMO compliance with certain State and federally prescribed QA standards, as well as a discussion of the nature of these standards. OIG should consider retitling the report and clarifying its statement of purpose in order to help the audience better understand the material presented.

Evaluative Methodology. The evaluative framework used to analyze and compare Medicaid QA standards is a structure, process, and outcome typology, which is difficult to follow in the body of the report. For example, on page 5, it is said that:

Structural and process standards do not tell us whether or not a patient was satisfied with the service, and may not detect under-utilization of services or the benefits of preventive health care and patient counseling.

Yet a chart on the same page defines process standards to include: utilization review, individual patient care data, clinical practice guidelines, and physician management. It seems that utilization review, individual patient care data, and clinical practice guidelines would all be expected to address under-utilization in some form, particularly when considering individual patients with poor health outcomes. There are no definitions of the items on this chart that might resolve the seeming contradiction.

We strongly recommend the evaluation contain an initial presentation of this complex framework, and thereafter, confine itself to the definitions it establishes therein. To assist with development of this framework, OIG may want to refer to: "Medicare: A Strategy for Quality Assurance" (Institute of Medicine, National Academy of Sciences, February 1990), for a presentation of the use of outcome, structure and process measures. This report was commissioned by Congress and is one of the principal sources of guidance for the Medicaid Managed Care QA program.

Findings. Though the report contains no recommendations for HCFA, it does present several significant findings. We believe the evaluative methodology has significant limitations, and therefore, we are concerned that these limitations have resulted in some inaccuracies in the findings presented. Also, many of the findings are in need of accompanying explanation to provide a proper context for a more general audience.

Technical Comments

Evaluation Design. There should be a discussion of the strengths and limitations of the evaluation design of this study, particularly since the scope of the evaluation excluded both QA activities conducted by independent quality review organizations under contract to State Medicaid agencies, and internal QA activities performed by HMOs. OIG also needs to explain how the sampled Medicaid agencies and HMOs were chosen.

Outcome Standards. This report repeatedly promotes the use of outcome-based QA standards in HMOs. However, this use of outcomes raises several issues:

- This report frequently associates outcome measures with patient satisfaction. However, the inability of patients to judge the quality of medical care they receive is broadly acknowledged as a quintessential obstacle in the analysis of the health care marketplace. If outcome and patient satisfaction are to be tied together, this obstacle should be discussed in the context of this report.
- In medicine, outcome analysis commonly refers to the use of clinical information data bases that rank post-treatment health status to select the most potentially successful treatment options for patients. This "science" is more or less in its infancy: such data bases do not now exist to an extent that they can be employed in routine medical practice. The founding of the Agency for Health Care Policy and Research in 1989 was spurred by recognition of the need to promote the development of such outcome-based research. The suggestion that this type of decisionmaking be used in contemporary HMOs seems premature.
- This report also suggests that Medicaid managed care is deficient in its use of outcome standards. However, the National Academy of Science's recent treatise on QA notes:
 - This emphasis on outcomes is a critical one. It will not, however, be easy to put into action, and it should never be seen as fully displacing process-of-care assessment Numerous aspects of outcome measurement should be understood before being considered appropriate for a quality assurance program Several disadvantages are associated with outcome measurement. The focus on aggregate data rather than individual or case-by-case analysis limits its usefulness in changing the practice behavior for the individual practitioner. Review is by definition historical; that is, after care has been delivered, instant intervention in serious situations where immediate action is justified to prevent a potentially bad outcome is not possible. The lack of demonstrated relationships

between outcome and process of care for many aspects of the management of patients is a major barrier to reliance on outcome measurement for QA programs.

In short, outcome standards must always be balanced with measures of structure and process to ensure high quality in medical care.

Managed Care Entities. The first paragraph on page two is confusing. It contains references to Preferred Provider Organizations (PPOs), indemnity coverage, premiums, and out-of-pocket costs, though none of these items are in use in the Medicaid program. On the next page, the report continues by saying: "the remaining Medicaid agencies use fee-for-service providers to serve Medicaid recipients or contract with other managed care plans, such as PPOs." Again, at this time, no Medicaid agencies contract with PPOs. OIG should also amend this report to reflect that CMP stands for "Competitive Medical Plan." Finally, OIG should consider examining QA in managed care settings other than HMOs in a future investigation.

HMOs. Four categories of HMOs are defined in the first two pages of this report: staff, group, network, and Individual Practice Association (IPA). These categories have questionable relevance since they are private-sector classifications not used by the Medicaid program.

Page seven contains the misleading statement that: "Federal and State laws require HMOs to submit marketing plans, procedures, and other materials to the Medicaid agency for approval." HMOs are not required to submit such information for approval prior to their use. Federal law does, however, prescribe certain standards applicable to HMO marketing materials, and States have responsibility for monitoring adherence to these standards. Additionally, some States have independent standards applicable to marketing materials.

The fourth paragraph of page nine states that: "recent court decisions hold HMOs financially responsible for the actions of their contracted physicians." There are several different lawsuits on HMO liability, each on a different subject, and each in a different stage of litigation. Therefore, we suggest this statement be modified to reflect these differences and account for the possibility of appeals to these decisions.

The fifth paragraph on page 12 outlines the actions HMOs may take to manage physician behavior. Action (3) is: "discipline the physician." We recommend this phrase be replaced with language that sounds less punitive or is more explanatory.

The report generally fails to make a distinction between federally qualified HMOs (as stipulated by Title 13 of the Public Health Service Act) and other HMOs subject to State and other standards. HMOs have different QA requirements depending on their qualification.

OIG should also note that many HMOs contracting with States are not at full risk since various risk-sharing arrangements are often in place. These HMOs may not be in the situation implied in the report in which the ability to control costs is the difference between success and failure for an HMO, and in turn, is likely to introduce negative incentives affecting the delivery of care to patients.

Medicaid HMO QA. All States must contract for independent quality reviews. These reviews provide important information to States that lead to various actions in HMO monitoring. This report makes several claims that States pass on QA responsibilities to HMOs and that this delegation is problematic. The assumption that this arrangement is problematic is not supported if these independent reviews find either the absence of problems or specific problems since, in both these cases, States have obtained the information needed for corrective actions. OIG should consider including information from States on this process in this report.

OIG should also acknowledge that QA in the Medicaid HMO program has several components:

- HMOs are required to conduct internal QA programs;
- State Medicaid agencies monitor, either directly or through a contractor, HMO compliance with certain State and Federally prescribed QA standards;
- States must utilize an independent contractor to review the quality of care provided by each HMO on an annual basis; and
- HMOs that contract with the Medicaid program or that are Federally qualified are also subject to review by Federal programs.

This evaluation focuses only on the second of these components.

Quality of Medical Care. The purpose of this report is stated as:

To describe the QA standards used by Medicaid agencies to minimize the risk of inappropriate medical care in HMOs.

Both this wording and the number of times the purpose of the report is repeated may cause the uninformed reader to assume that enrollment in an HMO carries significant risk of inappropriate care, despite the fact that no research exists to support this conclusion (reference: 1990 Department of Health and Human Services Report to Congress: "Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians").

The effect of such linking of concepts, without supporting documentation, could have a negative effect on public confidence in HMOs. Therefore, we recommend the original statement of purpose and all succeeding statements be amended to read:

To describe the QA standards used by Medicaid agencies for Medicaid contracting HMOs.

The statement is also made: "Patient care data received from HMOs often does not meet Medicaid agency expectations." Use of the term "expectations" does not make clear what objective data standards OIG means to cite. Medicaid agencies base their evaluations of HMOs on objective criteria.

Page 11 of the report says that practice guidelines aim to establish minimum standards of care. Practice guidelines are not minimum standards, but often are thought to promote use of "best practices" in medical care.

OIG RESPONSE TO HCFA COMMENTS

The HCFA felt that our draft report promoted the use of outcome based QA standards over structural and process standards-and that a balance of QA standards was more desirable. They also felt that the draft report might leave some readers with the incorrect impression that obtaining medical care from an HMO has greater risk of inappropriate care. In addition to these comments, the HCFA suggested that technical changes be made to the report which they felt would help the reader to better understand the Medicaid HMO environment and the methodology we used for our study.

With regard to HCFA's comments concerning:

Title, Purpose, Evaluation Methodology and Quality of Care: The report has been retitled and the purpose statement clarified. Additional information on how we classified a particular QA standard as structural, process or outcome and on how Medicaid agencies and HMOs were chosen has been added to the report.

The scope of this inspection did not analyze differences in quality of care which might exist between HMO and fee-for-service providers. Consequently, this issue was not addressed in this report.

Outcome Standards: We agree with HCFA that outcome standards must always be balanced with measures of structure and process to ensure high quality medical care in Medicaid contracting HMOs. We also agree that the "science" of health outcome analysis is "...more or less in its infancy..." We have clarified our definition of health outcome reviews to distinguish the health outcome medical record review QA standard from other health outcome initiatives that would use "... clinical information data bases that rank post-treatment health status to select the most successful treatment options for patients."

We believe that our clarification of health outcome medical record reviews addresses HCFA's concern that such reviews would displace process-of-care assessments. As defined, health outcome medical record reviews should enhance process-of-care assessments since they would take into consideration all care provided by the HMO, including preventative care and patient education and counseling.

We further agree that most patients are unable to judge the technical components of their medical care (i.e., the practice of medicine). However, recipients should not be discouraged from reporting what they believe to be inappropriate or poor medical care. In assessing the quality of HMO services, they can provide information about HMO facilities and practices and problems they encountered in accessing HMO services.

Managed Care Entities and Medicaid QA: The HCFA felt that our discussion of the various financial arrangements HMOs engage in was unnecessary in a report of

Medicaid HMOs. We included this information in the background section of our report to demonstrate the complex nature of the HMO marketplace. The business arrangements, sources of income and methods used for ensuring compliance have a direct impact on any QA efforts and should not be overlooked when developing a QA program.



Washington, D.C. 20002

APR 23 1992

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Quality Assurance in Medicaid
HMOs," OEI-05-92-00110

Thank you for providing me with an opportunity to review your draft report on quality assurance (QA) in Medicaid HMOs. The need for information in this area is great and growing, especially with the emphasis on Medicaid coordinated care articulated in the President's health care reform plan.

I would like to offer four comments on the draft report:

First, the methodology section should indicate on what basis the OIG chose the 28 HMOs it contacted for this review. What factors (e.g., size, duration of contract) were considered in selecting them? What percentage of the state's Medicaid HMO enrollment do these HMOs account for? Also, given the importance of Arizona in the Medicaid HMO realm, the reasons for its omission from this review are of interest and should be outlined.

Second, the report should discuss what federal legislation and regulations do and do not require concerning QA in Medicaid HMOs, both as general background and to put the findings of your review in context. To a greater extent than the report now suggests, federal requirements help to explain HMOs' and Medicaid agencies' current QA practices. For example, the report implies that Medicaid agencies have elected to carry over fee-for-service (FFS) process standards to their HMO programs (pages ii and 8). In fact, regulations at 42 CFR 434.34 require that Medicaid contracts with HMOs provide for an internal QA system that is consistent with the utilization control requirement for all Medicaid services, i.e., for FFS Medicaid.

Third, recognizing that your review is intended to be simply descriptive of QA in Medicaid HMOs, nonetheless, comparison to QA standards and practices in FFS Medicaid may be instructive in places, for example, in the discussion of clinical guidelines. HMOs have an uphill battle to wage partly because, despite a lack of evidence that it produces higher quality and better outcomes, traditional FFS is widely considered the standard of care. The absence from your report of important and relevant considerations (e.g., what happens in FFS, what happens in private industry, the state of the art in QA) makes it difficult and problematic to assess the findings. Additional contextual information would make the report more useful and valuable.

Page 2 - Richard P. Kusserow

Finally, you may wish to reflect in your report the Medicaid quality assurance reform proposal included in the FY 1993 budget and legislative package and/or the QA initiative now in development in the Medicaid Bureau.

If you have any questions, please call Elise Smith at 245-1870.


Martin H. Gerry

OIG RESPONSE TO ASPE COMMENTS

The ASPE suggested that additional information be provided in the background and methodology sections of the report. They also felt that information about QA in fee-for-service and the private sector would provide contextual information making the report more useful.

In response to ASPE's comments concerning:

Methodology: We have revised the methodology section of our report to address both ASPE's and HCFA's request for greater detail concerning our Medicaid agency and HMO sample selections.

Scope of study: This study was limited to QA standards required by Medicaid agencies. Information about QA standards in fee-for-service or the private sector was not within the scope of our study. Arizona was not included in our study because it contracts with prepaid health plans to provide services to Medicaid recipients and thus did not meet our criteria for inclusion in this study.

Additional Studies: The ASPE would have liked our report to provide more information about QA standards required by federal legislation. They would also have liked a comparison of HMO QA standards with fee-for-service QA standards and the QA standards of the private sector. Unfortunately, all of these issues were beyond the scope of this study, but would be worthwhile endeavors for future study.

As ASPE points out, HCFA is currently drafting its own QA program standards for managed care organizations as part of the "Quality Assurance Reform Initiative For Medicaid Managed Care."

APPENDIX D

ENDNOTES

1. U. S. Department of Health and Human Services, "The Fiscal Year 1992 Budget," and "The Fiscal Year 1993 Budget."
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