

**Memorandum**

Date AUG 27 1993

From Bryan B. Mitchell *Bryan Mitchell*
Principal Deputy Inspector GeneralSubject Office of Inspector General Concerns Pertaining to Safeguards Over Medicaid
Managed Care Programs (A-03-93-00200)To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final management advisory report entitled, "Office of Inspector General Concerns Pertaining to Safeguards Over Medicaid Managed Care Programs." The information in this report was previously provided to Congressman John Conyers, Chairman of the Committee on Government Operations, U.S. House of Representatives, at his request.

Mr. Conyers became aware that this office was nearing completion of a review of costs of the HealthPASS program in Philadelphia, Pennsylvania, which is a managed care program that is restricted solely to Medicaid recipients. Mr. Conyers believed that our audit of HealthPASS would enable us to provide insight into the adequacy of protections contained in the Medicaid Coordinated Care Improvement Act of 1992 Senate Bill (S.) 3191, against financial insolvency, poor quality care, and other managed care issues. He provided us a series of questions, and requested a response. He made the same request to the U.S. General Accounting Office (GAO).

On September 21, 1992, we responded to Mr. Conyers' request. Our review of S. 3191, and insight gained from our reviews of HealthPASS and International Medical Centers, Inc., a former managed care plan in Florida, led us to conclude that there was a need for additional safeguards over Medicaid managed care programs, beyond those included in S. 3191, to further reduce the risk of insolvency, some of the practices that oftentimes lead to insolvency, and poor quality of care.

Subsequent to the draft of this report, which was issued to the Health Care Financing Administration (HCFA) on October 15, 1992, we learned that S. 3191 was not enacted into law. The S. 3191 would have required the Secretary of Health and Human Services to promulgate regulations covering the solvency of managed care plans, and to develop a model contract to reflect those and other

requirements deemed appropriate. Despite the fact that this legislation was not passed, health care reform remains a major initiative of this Administration, and managed care appears to play an important role. We, therefore, believe this report still serves a purpose in that it contains recommendations to HCFA that should be considered in any proposed changes to Medicaid regulations dealing with managed care plans.

There are several safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. These safeguards include:

- establishing a minimum net worth for Medicaid managed care plans.
- restricting the plans' use of Medicaid funds by (1) establishing a medical escrow account to ensure that funds are available to pay for medical services, and (2) ensuring that related party transactions are arm's-length.
- establishing controls over the purchase of reinsurance by Medicaid managed care plans.
- developing a national rate-setting methodology and a method to determine what excess profit is and how it should be treated.
- requiring an annual audit of managed care plans.

We did not audit the quality of care provided under the HealthPASS contracts. Therefore, our response to Mr. Conyers on this subject was limited. We did, however, report on concerns that we shared with GAO relative to the transfer of risk from a managed care plan to a subcontractor or physician, and the sanctioning of managed care plans.

On May 26, 1993, HCFA provided written comments to our draft report. In its response, HCFA concurred with our recommendations to (1) use Medicare solvency guidelines, (2) establish minimum net worth standards, (3) develop a financial data base to measure the financial operations of managed care plans, and (4) establish time frames in which to apply sanctions against poor performing managed care plans. The HCFA did not agree with our remaining recommendations. Based upon our review of HCFA's response, we have made some changes to this report, including the deletion of certain recommendations.

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We believe, however, that the remaining recommendations in this report represent improved safeguards over insolvency that should be fully considered by HCFA.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-03-93-00200 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OFFICE OF INSPECTOR GENERAL
CONCERNS PERTAINING TO
SAFEGUARDS OVER MEDICAID
MANAGED CARE PROGRAMS**



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From Bryan B. Mitchell *Bryan Mitchell*
Principal Deputy Inspector General

Subject Office of Inspector General Concerns Pertaining to Safeguards Over Medicaid
Managed Care Programs (A-03-93-00200)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

The purpose of this management advisory report is to advise the Health Care Financing Administration (HCFA) of the Office of Inspector General's (OIG) concerns pertaining to safeguards over Medicaid managed care programs that were provided to Congressman John Conyers, Chairman of the Committee on Government Operations, U.S. House of Representatives, in response to his request.

Mr. Conyers became aware that the OIG was nearing completion of its review of cost of the HealthPASS program in Pennsylvania, which is a managed care program that is restricted solely to Medicaid recipients. About 82,000 Medicaid recipients residing in portions of Philadelphia, Pennsylvania participate in this managed care program. Mr. Conyers believed that our audit of HealthPASS would enable us to provide insight into the adequacy of protections contained in the Medicaid Coordinated Care Improvement Act of 1992 Senate Bill (S.) 3191, against financial insolvency, poor quality care, and other managed care issues.

We informed Mr. Conyers that our review of S. 3191, and insight gained from our reviews of HealthPASS and International Medical Centers, Inc. (IMC) in Florida led us to conclude that there is a need for improved safeguards over Medicaid managed care programs to reduce the risk of insolvency, some of the practices that oftentimes lead to insolvency, and poor quality of care.

Changes to Medicaid managed care regulations should include safeguards to protect recipients served by managed care plans, providers doing business with them, and the State and Federal governments that pay them.

The S. 3191 would have required the Secretary of Health and Human Services (HHS) to promulgate regulations covering the solvency of managed care plans, and to develop a model contract to reflect those and other requirements deemed appropriate. Our report would have enabled HCFA to consider our views on the adequacy of existing safeguards prior to promulgating the new regulations.

Subsequent to the issuance of our draft report on October 15, 1992, we learned that S. 3191 was not enacted into law. Despite this fact, health care reform remains a major initiative of this Administration, and managed care appears to play an important role. We, therefore, believe this report still serves a purpose in that it contains recommendations to HCFA that should be considered in any proposed changes to Medicaid regulations dealing with managed care plans.

These recommendations take into account HCFA's response to our draft report, dated May 26, 1993. The HCFA responded to each of our recommendations and made several general and technical comments. We have made several changes to this report based on HCFA's response, and have summarized the response along with our comments after the Conclusions and Recommendations sections of this report. The HCFA's response is included in its entirety as an appendix.

BACKGROUND AND METHODOLOGY

The Medicaid program is operated by the States, with Federal fund matching. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. Federal and State Medicaid spending increased 29 percent in 1992 to \$119 billion. Federal Medicaid spending alone is expected to reach \$84 billion during 1993, a 600 percent increase since 1980.

Managed care is broadly defined as the provision of health care through a single point of entry and through formal enrollment in a health care organization. By June 1992, 36 States and the District of Columbia had 1 or more managed care programs with a Medicaid enrollment of over 3.6 million recipients representing about 12 percent of the total Medicaid population. Medicaid managed care plans include health insuring organizations (HIO), health maintenance organizations (HMO), prepaid health plans (PHP), and primary care case management programs (PCCMP).

The S. 3191, introduced on August 12, 1992, proposed to amend the Social Security Act to increase States' flexibility to use coordinated care programs. The goal was to make it easier for States to enroll Medicaid recipients in managed care plans - HIOs, HMOs, PHPs, and PCCMPs. The most important provisions of the bill included:

- the elimination of the so-called 75-25 rule which requires that no more than 75 percent of the enrollees in an HMO with a comprehensive risk contract be Medicare or Medicaid eligible.
- a mandate that there be at least two managed health care plans in a specific area prior to allowing required enrollment in managed health care. As a result, States would no longer have to undergo the Federal waiver process every time one of them wishes to establish a mandatory managed care plan for Medicaid enrollees.
- a guarantee that community health centers will play an important role in the future development of managed care while at the same time allowing managed care plans to control their reimbursement to these centers.
- numerous provisions designed to strengthen quality assurance and protect recipients. These include requiring the Secretary of HHS to promulgate regulations covering the marketing practices and solvency of managed care plans.

The objective of this memorandum is to outline our response to Mr. Conyers' questions. Mr. Conyers became aware that our audit of HealthPASS was nearing completion. He submitted a list of questions to us regarding the protections incorporated into S. 3191. He submitted the same list to the General Accounting Office (GAO). He requested that we review S. 3191, and, based on experience gained through our audit of the HealthPASS contracts, respond to each question dealing with insolvency, poor quality of care, and other managed care issues.

Our response to Mr. Conyers was based primarily on our review of S. 3191, and our audit of the HealthPASS contracts awarded by the Pennsylvania Department of Public Welfare (State agency), which was made in accordance with generally accepted government auditing standards. Additional insight into managed care programs was gained through our past audit of IMC.

As you know, Congressman Henry A. Waxman, Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, requested the OIG to review the cost of the HealthPASS contracts awarded by the State agency. Mr. Waxman asked that we examine specific financial issues including the nature and financial effects of related party transactions entered into by the HealthPASS contractor, the reasonableness of the rate of return on invested capital, and the reasonableness of awarding the HealthPASS contractor a multi-year contract in view of the limited amount of capital contributed by the contractor.

We were not requested to review quality of care issues. Mr. Waxman requested that GAO review the quality of care provided by the HealthPASS contractor.

RESULTS OF REVIEW

SAFEGUARDS OVER INSOLVENCY OF MEDICAID MANAGED CARE PROGRAMS

Insolvency, which is a risk in any business enterprise including Medicaid managed care plans, can result from poor management, unexpected rising medical costs, failure of a reinsurer, or a poorly calculated capitation payment rate. Insolvency can also result from the deliberate draining of a plan's assets by owners, a parent company, or an acquiring corporation.

Insolvency could drive managed care plans out of business, leaving Medicaid recipients without access to health services.

Mr. Conyers questioned how Medicare protected itself against financially unstable plans, and whether similar safeguards should be applied to Medicaid managed care plans.

The GAO responded that Medicare has established some controls over the fiscal solvency of managed care plans. Medicare regulations specify a list of requirements such as, the managed care firm must have assets greater than liabilities, sufficient cash flow, and contingency plans in the case of insolvency. Medicare also requires that plans have (1) a minimum enrollment size and (2) operated successfully for a minimum period of time. These conditions help ensure that a plan is financially stable. Medicaid regulations allow States to impose specific requirements on contracting plans. The GAO concluded that

adoption of Medicare requirements by Medicaid could provide a better, but not absolute, assurance of financial stability.

We agree with GAO. We believe, however, that adoption of Medicare requirements by Medicaid could be augmented through the establishment of additional safeguards designed to ensure consistent and uniform oversight among the States. The safeguards that should be considered in any change of Medicaid regulations dealing with managed care plans include (1) mandating a minimum net worth for managed care plans, (2) restricting the plans' use of Medicaid funds, (3) establishing controls over reinsurance agreements, (4) establishing a uniform capitation rate-setting methodology and a method to determine what excess profit is and how it should be treated, and (5) requiring an annual audit of managed care plans.

Net Worth

We believe that a clear signal of an organization's fiscal stability is the net worth of that organization, that is, the relationship of the organization's assets to its liabilities. Obviously if an organization has a negative net worth (liabilities exceeding assets) the risk of it becoming insolvent is far greater than if the organization has a positive net worth of some significance.

Currently States determine what, if any, net worth requirements are applied to managed care plans. At the time that the HealthPASS contract was awarded to the current contractor, Pennsylvania law required that the contractor have a net worth of only \$100,000, and working capital of another \$100,000. This was for a multi-year contract valued at about \$633 million. This low net worth was a major concern to HCFA officials reviewing the contract for Federal approval.

One safeguard to consider, therefore, is to establish a requirement that managed care plans, their parent companies, and their subcontractors maintain a certain positive level of net worth, that is, a required level of assets over liabilities. This safeguard would help ensure that funds are available to pay providers for medical services and that services to recipients remain uninterrupted.

In determining the minimum level of net worth that should be required, there are other factors to be considered. For example, how will such a requirement affect the integrity of State procurements? Based on our review of the HealthPASS contracts, it appears as if the current contractor could have an unfair advantage should it and a new plan be required to meet the same

minimum net worth standard. We believe that consideration should be given to establishing separate standards for newly-formed and existing managed care plans to prevent any form of perceived bias against newly-formed plans, or perceived favoritism towards existing plans.

Another factor that should be considered is the nature and extent of other safeguards in place to reduce the risk of insolvency. The State agency, for example, established a medical escrow account to restrict the HealthPASS contractor's access to Medicaid funds until all provider payments were made, and required the contractor to acquire reinsurance to spread the risk of losses to a reinsurer.

We believe that additional safeguards, such as those described in the following paragraphs, can be used in combination with a requirement for a minimum net worth to reduce the risk of insolvency and help prevent abusive practices that oftentimes lead to insolvency.

Restricting the Plans' Use of Medicaid Funds

We understand that most contracts with managed care plans are fixed price. This, of course, means that the plans have general access to Medicaid funds. We believe that consideration should be given to restrict the plans' use of Medicaid funds by establishing a medical escrow account and by limiting related party transactions. Such actions will help ensure that funds are available to pay medical bills, and help prevent the deliberate draining of assets, thus further reducing the risk of financial insolvency.

Medical Escrow Account

The GAO reported that Oregon requires all managed care plans operating within that State to maintain restricted reserve funds in amounts approved by the State. Restricted reserve funds may be deposited in an escrow account or may be held by the plan, but the funds are not available for current operations of the plan.

A medical escrow account helps ensure that funds are available to pay for medical services. It can also be used to build up net worth of a managed care plan, an important consideration especially for newly-formed plans.

The Pennsylvania State agency also felt the need to limit access to Medicaid funds under the HealthPASS contract because of what it perceived to be a deliberate draining of assets by the parent company of a former contractor. The State agency established a medical escrow account under HealthPASS and deposited into this account that portion of the capitation fee earmarked for medical care. The remainder of the capitation fee was paid directly to the contractor to cover administrative costs. The contractor cannot withdraw funds from the escrow account without the express permission of the State agency.

The HealthPASS escrow account is not a statewide requirement for all managed care plans. We believe, however, that it is a good control that can be built upon to make it even more effective. As applied to HealthPASS, the medical escrow account prevents the plan from diverting funds earmarked for medical services to other uses until all medical bills are paid. Providers were particularly pleased with this safeguard as it assured them payment for services rendered to HealthPASS clients. Once periodic reconciliations disclose that the escrow account contains more than sufficient funds to cover all outstanding medical expenses, the State agency allows the contractor to receive distributions from the account.

We believe that excess funds should remain in the escrow account. And, excess funds should be considered part of the contractor's net worth, until a desired level of net worth is reached or the managed care contract expires. At that point, the State agency can distribute excess funds from the escrow account to the contractor.

Related Party Transactions

One avenue available to a plan's owners or parent company to gain access to the assets of an organization is through related party transactions. Generally accepted accounting principles (GAAP) require that related party transactions be disclosed in the financial statements of an entity. This disclosure, however, does not mean that the transactions were reasonable.

The GAAP makes it clear that one cannot assume that the transactions were arm's-length, and that an independent auditor does not have to make this determination unless the contractor's financial statement identified the transactions as being arm's-length. In other words, if the contractor does not declare the related party transactions to be arm's-length, the auditor is only

required to determine that all the transactions were disclosed. The auditor does not have to review them to determine if the costs were reasonable.

In our HealthPASS review, we determined that the contractor had identified related party transactions in the financial statements but did not report that they were arm's-length. Neither did the independent auditor that audited the financial statements. Our review showed that millions of dollars in payments were made to owners/directors and affiliated companies of the contractor. These payments did not threaten the contractor with insolvency. The payments did, however, increase the administrative costs of the HealthPASS program, and significantly reduced the contractor's pretax earnings that were reported to the State agency.

We believe that safeguards over related party transactions are needed if ever there is to be a true picture of the profitability of managed care plans. Without such a picture, identification of cost savings opportunities might well be missed. In the case of HealthPASS, we reported to the State agency what we believe the actual earnings of the contractor were for a 33-month period of operation. We recommended that the State agency consider the adjusted pretax earnings during its annual renegotiation of the current HealthPASS contract.

To prevent managed care plans from artificially reducing their earnings through less than arm's-length transactions, all related party transactions should not only be identified in the financial statements, but also be reviewed by either the State agency or an independent auditor to determine if they are arm's-length. The State agency should consider the costs of all related party transactions that are determined to be unreasonable as earnings in determining the plan's profit margin.

Reinsurance

Managed care plans act as an insurer to provide health care services to enrollees for a fixed capitated payment. The risk that the plan undertakes is that the capitated payments may not be sufficient to pay for all health care services. Thus the plan may suffer a financial loss. Managed care plans can underwrite the entire risk themselves or obtain reinsurance for all or a portion of the risk. Reinsurance is a contract under which one insurer agrees to indemnify another (in this case the managed care plan) with respect to actual losses sustained under the latter's policy or policies of insurance (in this case the managed care contract with the State agency).

Reinsurance may be a prudent means to protect against major loss and, therefore, insolvency. It could also be a major expense to the plan. There are many types of reinsurance arrangements. One type is called nonproportional aggregate excess of loss reinsurance. It is an expensive type of reinsurance designed to reimburse total losses up to a set amount during a specified period. Another type of reinsurance is specific stop loss reinsurance. Under this type of reinsurance, coverage is provided for individual expenses that exceed a deductible amount, such as \$30,000 per individual. This type of reinsurance arrangement is generally less costly than the aggregate type.

The current HealthPASS contractor chose aggregate reinsurance, which basically freed the Commonwealth of any financial risk up to the amount of the reinsurance coverage. This may well have been a prudent decision considering the experience of the previous HealthPASS contractor (parent company bankruptcy), but it was costly and impacted on administrative costs.

Our point is that the contractor made the decision to select aggregate reinsurance rather than other types that were available at a lower cost. This decision was made without the benefit of an actuarial review. We believe that, if reinsurance is to be purchased by a contractor, an actuarial review should be mandatory to determine the most effective and efficient reinsurance needed, considering geographic and demographic factors, the nature of the clients, and the solvency safeguards employed. Further, States should be required to approve in advance all reinsurance arrangements, including modifications, made by managed care plans under contract. As part of this process, States should determine that the reinsurers meet minimum standards of financial stability.

Capitation Rates

The S. 3191, as drafted, required that Medicaid payments to a managed care plan not exceed 100 percent of the costs the State would have incurred for the services in the absence of a contract. On the surface, it appears that this requirement was to ensure that managed care is more cost-effective than fee-for-service. It also appears that there would be less opportunities for profiteering, a concern Mr. Conyers expressed in his request to the OIG, since the plan would be reimbursed less than fee-for-service. In our opinion, however, additional safeguards are needed to ensure that managed care plans are, in fact, more cost-effective, and to reduce the risk of profiteering.

Cost-Effectiveness of Managed Care Plans

The Pennsylvania State agency contended that the HealthPASS contracts saved the Medicaid program about \$55 million in a 33-month period. The savings were due to the State agency negotiating a capitation payment rate significantly less than the comparable fee-for-service, and then renegotiating that rate downward as a result of a provision in the contract which allows for annual renegotiation of the rate.

We believe that the State agency's inclusion into the contract of a provision requiring annual renegotiation of the capitation payment rate was wise, and undoubtedly led to some savings. We cannot comment, however, on the accuracy of the \$55 million in savings attributable to the HealthPASS program because we did not audit the State agency's computation of the capitation payment rates, or the cost of the fee-for-service against which the rates were applied.

We were informed that although the payment methodology used by the State agency to reimburse the contractor was reviewed by independent parties, the implementation of the methodology was not reviewed. Therefore, there was no independent assessment of the accuracy of the capitation payment rates or the fee-for-service costs on which the rates were based.

Since establishment of the capitation payment methodology and its implementation is crucial to the success of managed care, we believe that HCFA should consider developing a uniform national rate-setting methodology. States should be required to utilize this methodology, and periodically undergo an independent evaluation of its implementation.

Profiteering

Mr. Conyers stated that profiteering in Medicare managed care programs has been an issue and that safeguards have been established to prevent it. He asked if S. 3191 had sufficient safeguards against profiteering and if Medicare safeguards should be applied to Medicaid managed care plans.

In responding, GAO stated Medicare has a safeguard which requires that excessive profits be returned to the program or fund additional benefits to beneficiaries. The GAO concluded that under S. 3191 profiteering could still occur, depending on how far the contractor lowers actual costs below the contract rate, or how accurate the State's rate-setting process is.

Medicare requires that excessive profits be returned to the program or fund additional services. We believe that Medicaid should have a similar requirement.

We agree that contractors could have earned significant profits under S. 3191. In our review of the HealthPASS contracts, we noted that in spite of being reimbursed less than the fee-for-service cost in Fiscal Year 1991, the contractor reaped significant pretax earnings when related party transactions were considered. The adjusted pretax earnings for that year exceeded the maximum profit margin guideline of 5 percent of revenue which was established by the Pennsylvania Department of Insurance (DOI). The DOI uses the guideline as a rule of thumb during the rate-setting process for measuring the reasonableness of profits of HMOs operating in Pennsylvania.

We did not imply in our draft report to the State agency that, by earning high profits, the contractor violated any of the terms of the contract, committed any other violations, or underserved HealthPASS recipients. We pointed out to the State agency that, based on the financial success of the contractor during its first 33 months of operation under the contracts, there was an opportunity for the State agency to initiate further cost savings by renegotiating a reduction in the capitation payment rate.

The HealthPASS contractor's profits were higher than the profit margin guideline established by the Pennsylvania DOI. But other States may have different guidelines, and other managed care plans may have higher profits. In this regard, the HealthPASS contractor, in responding to our draft report, provided us with a financial analysis of the managed care industry prepared by a management consulting firm and paid for by the contractor. The analysis included a review of a number of Medicaid managed care plans and commercial plans, none of which reported losses in either 1990 or 1991, the 2 years covered by the analysis. According to the analysis, the contractor's profitability was within the norms of its peer managed care organizations.

We did not validate the data contained in this analysis, but the point made by the analysis is well taken. According to the analysis, Medicaid managed care plans are more profitable than their commercial counterparts. A comparison of profits earned by Medicaid managed care plans with at least 50 percent Medicaid enrollment and all commercial managed care plans in the Mid-Atlantic region (New York, New Jersey, Pennsylvania, Maryland, Delaware, and Virginia) showed that the Medicaid managed care plans' pretax income in 1991 averaged 10 percent of premiums as compared to 5 percent for the commercial plans.

We believe that a safeguard, similar to Medicare's, where excessive profits are returned to the program or used to fund additional services, should be applied to Medicaid managed care plans. To do this, however, HCFA first needs to determine what constitutes an excessive profit.

Audit of Managed Care Plans

The S. 3191 would have allowed States to review the financial records of the contracting entity and subcontractors for their ability to bear the risk of potential financial losses. We believe that Medicaid regulations should include a requirement that an annual audit of the managed care plans' financial statements be submitted to the State agency. This information should be reviewed by the State agency to help assess the financial solvency of managed care plans on an ongoing basis. Currently it is left to the States to determine if annual audits are required. The State agency did require the HealthPASS contractor to submit an annual audit.

To the maximum extent possible, financial information should be reported separately for Medicaid, Medicare, and private lines of business. Without segmented information, it is difficult to assess whether adequate (or in some cases excessive) Federal/State payments are being made to managed care plans.

In addition to auditing the contractor, we believe that there should be provisions made to ensure that States require periodic audits of plans' parent companies and subcontractors. This safeguard will help ensure uninterrupted care to Medicaid recipients.

Conclusions and Recommendations

Given growing interest and support for Medicaid managed care programs as a means to better control health costs, it appears that the Congress may act to

encourage the expanded use of these programs. It is critical, therefore, that HHS have safeguards to ensure that managed care plans are well managed, and that insolvency protections are in place. These same protections can also help to reduce the risk of other abusive practices, such as the deliberate draining of a plan's assets and profiteering.

We believe that, even with these safeguards, it is necessary for HCFA to retain its review and approval role over contracts awarded for Medicaid managed care plans. In fact, we believe that HCFA's role should be expanded so that it would be in a position to maintain a national data base of information derived from managed care plans' audited financial statements. Such a data base could alert HCFA as to how well States monitor Medicaid managed care plans, and could detect patterns that could lead to the identification of weaknesses within these plans.

We recommend that, when making any changes to Medicaid regulations over managed care plans, HCFA consider applying Medicare safeguards to Medicaid managed care plans. In addition to taking this step, the following safeguards should be considered.

1. Establishment of a Federal standard for minimum net worth of an organization bidding for a Medicaid managed care contract. Consideration should be given to separate standards for newly-formed and existing managed care plans to prevent any form of perceived bias against newly-formed contractors or perceived favoritism towards existing plans. The standard should apply to subcontractors, as well as to the managed care plans.
2. Mandate use of a medical escrow account to safeguard the portion of the capitation fee needed for the payment of medical services provided to Medicaid recipients.
3. A requirement that all related party transactions be reviewed by the State agency or an independent auditor to determine if they represent arm's-length transactions, and are reasonable. Such a requirement could be incorporated into the audit clause provision of the model contract.
4. A requirement that reinsurance purchased by Medicaid managed care plans be based on actuarial studies and approved by the State

agency. Reinsurers should be required to meet minimum standards of financial stability.

5. A requirement that States use a national rate-setting methodology developed by HCFA, and periodically have an independent assessment performed of their implementation of this methodology.
6. Development of a method to determine what excess profit is and how it should be treated.
7. A requirement that States require an annual audit of managed care plans, and periodic audits of the plans' parent company and subcontractors.
8. Development of a HCFA data base to measure the financial operations of managed care plans. The basis for this data base could be the plans' annual audit reports.

HCFA Response and OIG Comments

The HCFA commented on each of the recommendations in the draft report and made several general and technical comments as well. Based on HCFA's response, we made several changes to the report. Before discussing HCFA's response to each of the recommendations contained in the draft report, we would first like to address a major concern of HCFA's relative to the scope of this review.

The HCFA expressed concern that we based all of our conclusions on two Medicaid managed care programs that were not, in the opinion of HCFA, representative of most Medicaid managed care programs. Because of this limited scope, HCFA believes that the report's conclusions are not appropriate.

We agree that our recommendations were developed based on our reviews at two managed care plans and our analysis of the provisions of S. 3191. We do not agree with HCFA that the limited scope of this review makes our conclusions inappropriate.

As pointed out by HCFA in its response, our recommendations were developed in the context of a review of S. 3191, a bill that would have made major changes in the Medicaid managed care environment. The bill contained numerous

provisions designed to strengthen quality assurance and protect recipients, and required the Secretary of HHS to promulgate regulations covering the solvency of managed care plans and to develop a model contract to reflect those and other requirements deemed appropriate. We were specifically asked by Mr. Conyers for our opinion of the adequacy of the safeguards contained in S. 3191 based on our review of HealthPASS.

In performing this review, we compared the safeguards offered by S. 3191 to the results of our review of the HealthPASS contracts, and determined that additional safeguards should be considered beyond those included in S. 3191. Some of these additional safeguards that we believe should be considered were used effectively by the Pennsylvania State agency that monitored the HealthPASS contract. Conversely, some of the possible safeguards were not used by the Pennsylvania State agency because they were not required by Federal regulation. This latter category of safeguards, had they been implemented by the Pennsylvania State agency, would have precluded or at least detected certain problems that we identified during our HealthPASS review.

We provided Mr. Conyers with the information requested, and believed that we should inform HCFA of our conclusions for its consideration in preparing the regulations required by S. 3191. The fact that S. 3191 was not enacted does not change our opinion that the safeguards recommended in this report would strengthen oversight of Medicaid managed care programs by both HCFA and the State agencies charged with the oversight responsibility.

In responding to our recommendations in the draft report, HCFA agreed with our recommendations to consider: (1) Medicare solvency guidelines when establishing Medicaid guidelines, (2) minimum net worth standards for new and existing Medicaid managed care plans, and (3) development of a financial data base to measure the financial operations of managed care plans. The HCFA did not concur with our remaining recommendations which are discussed below.

The HCFA did not agree with our recommendations for a medical expense escrow account or that reinsurance arrangements be based on actuarial studies. The HCFA responded that these safeguards represent only two of several viable financial safeguard options available to managed care plans. Other options include hold harmless provisions, continuation of benefits provisions, letters of credit, third-party guarantees, or participation in State guaranty funds at States' discretion.

We agree that the medical expense escrow account and reinsurance are two of several viable financial safeguards. Insofar as the escrow account is concerned, the Pennsylvania State agency used it to control the contractor's access to Medicaid funds to ensure that funds would be available to pay providers. We believe this is a very effective "front-end" control that should be considered for implementation nationwide. The HealthPASS providers are comfortable with this control as it assures them payment. In fact, after the bankruptcy of the parent company of the prior HealthPASS contractor, several major hospitals refused to enter into new provider agreements until the State agency implemented the medical expense escrow account. It is likely that such a control would be a strong incentive for providers to participate in managed care programs nationally.

With regard to reinsurance, we did not recommend that reinsurance itself be considered for mandatory implementation, but only that reinsurance be based on actuarial studies once the determination has been made that reinsurance will be purchased. We recognize that reinsurance is dynamic and can be tailored to meet the needs of individual managed care programs. Selecting the wrong type or amount of reinsurance, or a financially unsound reinsurer, can be a costly mistake. For this reason, it makes sense that the type and amount of reinsurance be based on actuarial studies.

The HCFA did not agree with our recommendation to require that all related party transactions be reviewed for reasonableness because it does not believe that excessive use of related party transactions by managed care plans is a widespread problem. The HCFA stated that it would welcome an OIG assessment of the extent of this problem in Medicaid managed care programs nationally.

Excessive use of related party transactions may not be a widespread problem as suggested by HCFA, but problems have been detected in the past. For example, in 1985 the GAO reported that Medicaid managed care programs in Arizona had not properly disclosed significant related party transactions. The GAO concluded that underserving of the Medicaid population may occur if program payments are used to pay unnecessary administrative costs or excessive profits to related parties rather than to provide medical services.

We found problems with related party transactions in our HealthPASS review. While we did not determine that these problems resulted in the withholding of services from the Medicaid population served by the contractor, we did determine that related party transactions resulted in the contractor's reported

profits to be understated. Without an accurate picture of profits, the State agency missed an opportunity for further Medicaid savings.

If HCFA intends to implement a national data base as indicated, we believe that it should require all related party transactions to be reviewed for reasonableness. Otherwise the financial data entered into the system may not be totally accurate.

The HCFA did not concur with our recommendations that HCFA develop a national rate setting methodology. They stated that current Federal regulations require HCFA to determine that managed care rates are actuarially sound, and require that managed care rates not exceed the Federal upper payment limit. As long as these requirements are met, HCFA does not believe that it is necessary to develop a national rate setting methodology. In addition, HCFA has contracted for actuarial studies of acceptable rate setting methodologies that States may elect to use.

We believe that HCFA's action to contract for actuarial studies of acceptable rate setting methodologies generally meets the intent of our recommendation. However, if HCFA determines that States are not using these acceptable methodologies, the States should be required to justify the rate setting methodologies that are used.

The HCFA did not agree with our recommendation to develop a method to determine what excess profit is and how it should be treated stating that it lacks authority under the current law to address excess profits. The HCFA also stated that for States which provide cost-effective care in the sense of meeting acceptable quality, access and pricing parameters, it is not clear that a definition of excessive profit is necessary.

We disagree with HCFA. A definition of excessive profits for Medicaid managed care plans is necessary in order to apply a safeguard over excessive profits similar to that applied to Medicare funds. It is possible for a managed care program to have acceptable pricing in terms of being less than the fee-for-service costs and still result in significant high profits for the contractor. This situation occurred with HealthPASS and, based on information provided to us by the HealthPASS contractor, may be occurring with other managed care contractors as well. The Federal and State governments must continue to work towards the goal of becoming prudent purchasers of health care services, and maximizing savings available to the Medicaid program through controlling profit is one way of achieving this goal. If HCFA believes that it lacks authority under current law

to address the issue of excessive profits, it should seek appropriate legislative changes.

The HCFA did not concur with our recommendation that States should require an annual audit of managed care plans. The HCFA agrees with the need for outside audits but would not want to impose requirements that duplicate oversight performed by other entities, such as the State Commissioners of Insurance. This duplication would represent a major administrative burden for States and could have a very negative effect on the willingness of potential contractors to participate in the Medicaid program. The HCFA, however, stated that it recognizes the need for effective financial oversight of managed care plans and will consider how this can be accomplished in conjunction with the requirements of other regulators.

We did not intend by making this recommendation to duplicate the audit process. Rather, the State agencies responsible for overseeing the Medicaid managed care programs should be required to obtain annually the audited financial statements of the contractors, whether the audits result from a requirement of the State Commissioners of Insurance or the State Medicaid agencies, in order to assess the financial solvency of the programs, and to assess, on an ongoing basis, the reasonableness of the capitation payments.

We do not foresee the need for duplicate audits, nor the creation of a major administrative burden for the States. To the contrary, we question how a State agency could effectively carry out its oversight function of Medicaid managed care plans without annual audits being required.

Furthermore, we believe that HCFA's proposed financial data base would be adversely affected if the information entered into that base was not the result of audited financial statements.

QUALITY OF CARE PROVIDED BY MANAGED CARE PLANS

Congressman Conyers raised several questions about safeguards in S. 3191 over the quality of care provided by managed care plans. Since our review at HealthPASS was restricted to cost issues (GAO was requested to review quality care issues at HealthPASS), our response to Mr. Conyers was limited. There is, however, some concerns that we share with GAO.

Transfer of Risk

In GAO's investigation of the Chicago area HMOs (Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area, GAO/HRD-90-81), it found that several plans transferred much of the financial risk for the cost of care to medical groups or individual practice associations, which subcontract with the HMOs and that subcontractors may in turn transfer risk to primary physicians. In GAO's opinion these arrangements permitted the transfer of excessive risk to individual physicians and created strong disincentives to furnish care.

Mr. Conyers requested that GAO and the OIG identify and evaluate those provisions of S. 3191 which specifically address the practice of transfer of financial risk by managed care plans to subcontractors and to individual physicians. Both GAO and the OIG concluded that S. 3191 would have allowed for the audit and inspection of any books and records of a managed care plan and its subcontractors. The Omnibus Budget Reconciliation Act of 1990 limited the financial incentives that can be placed on an individual physician. However, proposed regulations defining what level of risk is too high were not published at the time our audit work was performed.

Under financial risk contracts with managed care plans, there is a potential for the risk to be transferred to subcontractors. These subcontractors can be physicians, community health centers, or even hospitals. A prime example of the problems that can develop with the transferring of risk is IMC which operated in Florida during the 1980's. The IMC had established a network of health care providers who were given a per member, per month allocation from the Medicare capitated payment. In return, the providers in the network assumed the risk of providing all needed care to the beneficiaries. As IMC reduced the monthly allocation, or withheld funds for administrative charges, the providers found themselves without the needed funds to provide adequate services to the beneficiaries.

Requiring the submission of detailed information on the arrangements with subcontractors and periodic reporting on the funds allocated to the network providers, relative to the volume of services they have to render, would be needed to assess the reasonableness of the subcontractor payments. This reporting and subsequent analysis process will be costly to implement but it is necessary to ensure that managed care plans are not transferring their financial risk without adequately compensating the providers who are assuming the risk.

Sanctioning Managed Care Plans

The same GAO investigation also determined that the State provided inadequate follow-up action when quality of care problems were identified. Mr. Conyers requested that GAO and the OIG identify all provisions of S. 3191 pertaining to State actions in the event of inadequate plan performance and assess whether the provisions assure timely State action.

The S. 3191 expressly would have authorized States to terminate contracts for noncompliance with the terms of the contract or any applicable provision of the law. The bill also would have retained the States' existing authority to impose intermediate fiscal sanctions, short of termination. Those provisions give States the authority to take action when they identify any problems, but do not require action or set a specific time frame for it. We believe that such sanctions should be required and that specific time frames for their implementation should be developed.

Conclusions and Recommendations

We did not audit the quality of care provided by the HealthPASS contractor or IMC. We do, however, share some of the same concerns expressed by GAO. We believe that these concerns should be addressed in any changes to Medicaid regulations over managed care programs.

We, therefore, recommend that HCFA:

1. conduct a study to quantify the level of risk that can be transferred from a plan to a subcontractor.
2. mandate that sanctions against poor performing managed care plans be implemented within a specific time frame.

HCFA Response and OIG Comments

In its written response, HCFA agreed with our recommendation to mandate that sanctions against poor performing managed care plans be implemented within a specific time frame.

The HCFA did not agree with our recommendation to conduct a study to quantify the level of risk that can be transferred from a plan to a subcontractor.

The HCFA pointed out that a study is no longer necessary since in December 1992, HCFA issued proposed regulations that would require an HMO to submit to the State a detailed description of its financial incentive plans for all subcontractors in order that the State may determine the level of financial risk at which a plan places its subcontractors.

At the time we issued our draft management advisory report, HCFA had not issued the proposed regulations. These proposed regulations were issued for comments in December 1992, however, as of the date of this report, they have not been finalized. We believe that these proposed regulations meet the intent of our recommendation. The proposed regulations will require all HMOs to submit to the Medicaid State agency a detailed description of its financial incentive plans for all subcontractors in order that the State may determine the level of financial risk at which a plan places its subcontractors. The proposed regulations also define quantitatively what constitutes substantial financial risk and authorize the use of intermediate sanctions and civil monetary penalties.

**Memorandum**

Date

MAY 26 1993

From

William Toby, Jr.
William Toby, Jr.
Acting Administrator

Subject

Office of Inspector General (OIG) Draft Management Advisory Report: "Office of Inspector General Concerns Pertaining to Safeguards Over Medicaid Managed Care Programs," A-03-93-00200

To

Bryan B. Mitchell
Principal Deputy Inspector General

We reviewed the subject draft management advisory report which concerns the adequacy of safeguards over Medicaid managed care programs to reduce the risk of insolvency and poor quality of care. Congressman John Conyers, Chairman of the Committee on Government Operations, U.S. House of Representatives, requested that OIG and the United States General Accounting Office provide information that he could use to assess the adequacy of protections contained in the Medicaid Coordinated Care Improvement Act of 1992 (S. 3191). We note you have already provided Congressman Conyers a draft copy of your report.

OIG found that there is a need for improved safeguards over Medicaid managed care programs to reduce the risk of insolvency.

HCFA concurs with the recommendations in the report regarding minimum net worth, development of a national data base to measure the financial operations of managed care plans, and timeframes for sanctions against poorly performing managed care plans. HCFA also agrees that Medicaid should consider Medicare solvency guidelines in establishing Medicaid guidelines, but notes that it is equally important to take into consideration the differences in the two programs, and consider State insurance standards as well.

HCFA nonconcurrs with the remaining recommendations. Please note that your recommendations were developed in the context of a review of S. 3191, a bill that would have made major changes in the Medicaid managed care environment. However, our comments are within the context of current law.

Thank you for the opportunity to review and comment on this draft management advisory report. Please advise us if you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Management Advisory
Report: "Office of Inspector General Concerns Pertaining to
Safeguards Over Medicaid Managed Care Programs
A-03-93-00200

Recommendation 1

HCFA should consider applying Medicare safeguards to Medicaid managed care plans.

HCFA Response

HCFA will consider applying Medicare safeguards to Medicaid managed care plans. We agree that adequate safeguards are necessary to guarantee the quality of services provided by Medicaid plans and to ensure the fiscal solvency of those plans. However, the nature of the Medicaid program is fundamentally different from the nature of the Medicare program. While Medicare program guidelines can be uniformly enforced because of the singularity of that program, Medicaid guidelines may need to allow for differences among Medicaid State plans. Therefore, we believe that Medicaid guidelines should be examined in light of these differences. In addition to the Medicare guidelines, we believe that, to the extent possible, any Medicaid guidelines should strongly consider standards established by the State offices of the Commissioners of Insurance, since Medicaid is a State-administered program.

Recommendation 2

HCFA should consider this safeguard:

- o A Federal standard for minimum net worth of an organization bidding for a Medicaid managed care contract. Consideration should be given to separate standards for newly formed and existing managed care plans to prevent any form of perceived bias against newly formed contractors or perceived favoritism towards existing plans. The standard should apply to subcontractors as well as to the managed care plans.

HCFA Response

We agree that some standards are appropriate. Provisions requiring such standards were included in the Medicaid Coordinated Care Improvement Act of 1992 for risk contracting entities and supported by the Department of Health and Human Services (HHS). All but five States already have minimum net worth requirements.

We agree that consideration should be given to separate minimum net worth standards for newly formed and existing plans. We believe that differences in net worth requirements may also be appropriate based on the extent of contractor risk and the projected volume of enrollees. We also agree that these standards should be applied to subcontractors. However, we believe that it may be appropriate to allow State Medicaid agencies to delegate the responsibility for ensuring a subcontractor's compliance with solvency standards to the contracting managed care plan.

Recommendation 3

HCFA should consider this safeguard:

- o Mandated use of a medical escrow account to safeguard the portion of the capitation fee needed for the payment of medical services provided to Medicaid recipients.

HCFA Response

HCFA does not concur with the recommendation. Most States currently do not require this escrow account. This is only one of several viable options available for plans to ensure availability of funds for payment of medical services in the case of insolvency. Other arrangements that a plan may make to cover health care expenses for beneficiaries include: insolvency insurance, hold harmless provisions, continuation of benefits provisions, letters of credit, third-party guarantees, or participation in State guaranty funds at States' discretion.

Recommendation 4

HCFA should consider this safeguard:

- o A requirement that all related party transactions be reviewed by the State agency or an independent auditor to determine if they represent arm's length transactions, and are reasonable. Such a requirement could be incorporated into the audit clause provision of the model contract.

HCFA Response

HCFA does not concur with the recommendation. We recognize that this has been an issue in the one Medicaid managed care program reviewed by OIG. However, we do not believe that the reviewed managed care program is representative of other programs. We would welcome an OIG assessment of the extent of this problem in Medicaid managed care programs nationally.

Recommendation 5

HCFA should consider this safeguard:

- o A requirement that reinsurance purchased by Medicaid managed care plans be based on actuarial studies and approved by the State Medicaid agency. Reinsurers should be required to meet minimum standards of financial stability.

HCFA Response

HCFA does not concur with the recommendation. Like the mandated use of medical escrow accounts, reinsurance requirements are only one of several viable options available for States to ensure against insolvency. We believe that it is appropriate for States to select the fiscal solvency protection options suitable for their State.

Recommendation 6

HCFA should consider this safeguard:

- o A requirement that States use a national ratesetting methodology developed by HCFA, and periodically have an independent assessment performed of their implementation of this methodology.

HCFA Response

HCFA does not concur with the recommendation. We do not believe that a national ratesetting methodology would be more productive than allowing States to determine the ratesetting methodology most appropriate to their own circumstances, as long as that methodology produces actuarially sound rates and the rates produced do not exceed the upper payment limit as set forth in Federal regulations at 42 CFR 447.361.

There are many different models of managed care contracting in the 37 States that currently have managed care programs. We do not believe that anything is to be gained from mandating one ratesetting methodology for all States. Ratesetting methodologies used in prepaid managed care systems may vary for a number of reasons, including but not limited to: length of time a program has been operational and length of time from the base year, use of mandatory or voluntary enrollment, extent to which the fee-for-service base has been eroded, incorporation of savings incentives, and nature of a State's data system.

Federal regulations at 42 CFR 431.23 require HCFA to determine that managed care rates are actuarially sound, and Federal regulations at 42 CFR 447.361 require that managed care rates do not exceed the upper payment limit. HCFA has contracted for actuarial assistance in the form of studies of acceptable ratesetting methodologies that States may elect to use. As long as these requirements are met, we do not believe that it is necessary to develop a national ratesetting methodology.

Recommendation 7

HCFA should consider this safeguard:

- o A requirement that all Medicaid managed care contracts include an annual renegotiation provision; whereby, the capitation payment rate can be renegotiated based on the plan's earnings.

HCFA Response

HCFA does not concur with the recommendation. Since all States already renegotiate their managed care contracts annually, we see no need to mandate yet another requirement.

Recommendation 8

HCFA should consider this safeguard:

- o Development of a method to determine what excess profit is and how it should be treated.

HCFA Response

HCFA does not concur with the recommendation. HCFA lacks authority under current law to address this issue. States are responsible for setting rates which guarantee access to services and quality of care within an upper payment limit, which is defined as the cost of a given service package under the fee-for-service system. It is HCFA's responsibility to ensure that States have met this general requirement. In effect, this recommendation could be interpreted as suggesting that States treat managed care plans as quasi-public utilities requiring regulation of rates-of-return. For States which provide cost-effective care in the sense of meeting acceptable quality, access and pricing parameters, it is not clear that a definition of "excessive profit" is necessary.

Recommendation 9

HCFA should consider this safeguard:

- o A requirement that States require an annual audit of managed care plans, and periodic audits of the plans' parent company and subcontractors.

HCFA Response

HCFA does not concur with the recommendation. While we agree with the need for managed care plans to have outside audits performed by independent auditors, we would not want to impose requirements that duplicate oversight performed by other entities. The majority of HMOs with Medicaid managed care contracts are State certified and already have such audits performed by the State Commissioners of Insurance. In the event that a State determines that an audit of a managed care plan is necessary, the State has the authority to perform an audit under current regulations.

We believe that to require annual audits of entities beyond what is currently performed would be duplicative in many cases and would represent a major administrative burden for States. In addition, such a policy could have a very negative effect on the willingness of potential contractors to participate in the Medicaid program.

However, we recognize the need for effective oversight of the financial performance of managed care plans and will consider how this can be accomplished in conjunction with the requirements of other regulators.

Recommendation 10

HCFA should consider this safeguard:

- o Development of a HCFA data base to measure the financial operations of managed care plans. The basis for this data base could be the plans' annual audit reports.

HCFA Response

HCFA concurs with the recommendation. We believe that developing a financial data base with some financial data from managed care plans has merit and are currently working toward that end with national groups concerned with coordinated care plans.

Recommendation 11

HCFA should conduct a study to quantify the level of risk that can be transferred from a plan to a subcontractor.

HCFA Response

HCFA does not concur with the recommendation. In 1990, HHS conducted a study commissioned by Congress and undertaken in consultation with Lewin, ICF, entitled "Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians." This study was the basis for the proposed regulations published in December 1992, "Requirements for Physicians Incentive Plans in Prepaid Health Care Organizations - Medicare and Medicaid." These proposed regulations would:

- o require all HMOs to submit to the Medicaid State agency a detailed description of its financial incentive plans for all subcontractors in order that the State may determine the level of financial risk at which a plan places its subcontractors;
- o define quantitatively what constitutes, "substantial financial risk," and
- o authorize the use of intermediate sanctions and civil monetary penalties against plans which fail to disclose such information or which place providers at "substantial financial risk" without meeting requirements for providing all such subcontractors with adequate and appropriate "stop-loss" protection, as quantitatively defined by the Secretary.

In view of this recent study and the impending regulations, we believe it would be duplicative to conduct a new study. The forthcoming regulations already quantify the level of risk that can be transferred from a plan to subcontractors and require the submission of detailed information on the arrangements with subcontractors.

Because of the substantial information to be collected and analyzed under the forthcoming rule, we do not believe it would be necessary or cost-effective to require additional reporting for the purpose of assessing the reasonableness of subcontractor payments. If OIG wishes HCFA to reconsider this proposal, an analysis of the full cost of the proposal versus the possible incremental benefit to be achieved by the additional collection and analysis of information would be helpful.

Recommendation 12

HCFA should mandate that sanctions against poor performing managed care plans be implemented within a specific timeframe.

HCFA Response

HCFA concurs with the recommendation. HCFA has published a proposed rule, "Civil Monetary Penalties and Intermediate Sanctions for Certain Violations by Health Maintenance Organizations and Competitive Medical Plans" (Federal Register, Volume 56, No. 140, dated July 22, 1991), which specifies timeframes for the impositions of sanctions.

Recommendation 13

HCFA should, if permitted by law, require that all managed care plans, regardless of size, be subject to quality assurance safeguards.

HCFA Response

HCFA does not concur with the recommendation because all capitated or other risk-based managed care plans are already subject by law to quality assurance safeguards. In addition to this requirement, all plans are required to have an annual external quality assurance review conducted by either the State Medicaid agency or an independent contractor.

As part of HCFA's Quality Assurance Reform Initiative for Medicaid Managed Care, begun by HCFA in 1991, a Health Care Quality Improvement System has been designed for risk-reimbursed Medicaid managed care programs. This system will provide intensive technical assistance to States in designing more effective quality assurance systems for their managed care programs. Phase I of this initiative, which is nearly completed, has resulted in the following guidelines:

- o "Specifications for a Health Care Quality Improvement System for Risk-Reimbursement Medicaid Coordinated Care Programs,"
- o "Guidelines for Internal Quality Assurance Programs of HMOs, Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs) Contracting with Medicaid,"

- o "Clinical and Health Services Delivery Areas of Concern, Quality Indicators, and Clinical Practice Guidelines for Quality Improvement in Medicaid Coordinated Care," and
- o "Specifications for External Quality Review of Risk-Reimbursement Medicaid Coordinated Care Organizations."

During Phase II of this initiative, HCFA will be directing the implementation of these guidelines and providing technical assistance to State Medicaid agencies.

General Comments

HCFA is concerned that OIG based all of their conclusions on one Medicaid managed care program called HealthPASS that was operated by Maxicare, and a former Medicare HMO, International Medical Centers, Inc. (IMC), that operated in south Florida in the 1980s. Unfortunately, the programs that were chosen for this report are not representative of most Medicaid managed care programs. In fact, HealthPASS is unique. It is the only health insuring organization (HIO) operating a program with mandatory enrollment in an urban setting. In addition, this type of managed care program can no longer be replicated elsewhere in the country, without legislative change, due to provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which subjected HIOs with Medicaid contracts that arrange for comprehensive services on a risk basis, to the same requirements as HMOs. HealthPASS was in existence when COBRA passed, and was "grandfathered," or excepted, from the new COBRA requirements.

At present, there are approximately 235 Medicaid managed care programs operating in 37 States. Of the 235, only 5 are HIOs, and 4 of these cannot be compared to HealthPASS in terms of service area, population, or management entity. Besides the HIOs, there are 132 HMOs, 76 PHPs, and 22 primary care case management programs. Both within and across these basic types of organizations, there are great differences in terms of payment mechanisms, benefit packages, risk limits, service areas, and type of State plan or waiver authority under which the program operates.

Given this diversity of health care delivery systems, we are concerned that OIG based several of its conclusions on an evaluation of HealthPASS. We believe that the report's conclusions are not appropriate for this reason.

We are also concerned at the implication that OIG reviews have lead them "to conclude that there is a need for improved safeguards . . . to reduce the risk of insolvency, and poor quality of care." You note that insolvency could drive managed care plans out of business, leaving Medicaid recipients without access to health

services. We wish to point out that contractor insolvency has not created a problem in access to care for Medicaid recipients. In fact, due to HCFA's regulatory requirements, contractor insolvency has been a rare occurrence.

The most notable instance occurred when Maxicare filed for bankruptcy protection in 1989. HealthPASS was one of the programs operated by a Maxicare subcontractor at the time. Extensive monitoring by the State and HCFA did not document a single instance of Medicaid recipients being denied care as a result of this insolvency. This was also true in other programs where Maxicare contracted with a State Medicaid agency. One inherent protection against Medicaid recipients being denied access to health care services in a managed care environment is that if the managed care plan fails, recipients may obtain services from the fee-for-service system.

In addition to the access to care issue, on page 18, the report states that OIG did not audit the quality of care provided by either HealthPASS or IMC. Therefore, we believe that OIG should not comment that the risk of insolvency could decrease recipients' access to care or affect the quality of care provided, and should comment only on its findings relative to reducing the risk of insolvency.

Technical Comments

1. On page 1, HealthPASS is described as the "largest managed care program in the country that is restricted solely to Medicaid recipients." This is not an accurate statement. Medicaid managed care programs in a number of States, including Wisconsin, Colorado, Massachusetts, Arizona, and Kentucky, have more enrollees than HealthPASS.
2. The last sentence on page 2, and the third full sentence on page 3 of the draft report should be revised to add "prepaid health plans (PHP)." While PHP is a Medicaid term and is not used generally like the terms HMO and PPO, this is equally true of the terms HIO and PCCMP, which are included in the sentence. Indeed, the only term in the sentence that is not used as a Medicaid term is PPO. A PPO would contract with Medicaid as either a PHP or an HMO. Therefore, it might be preferable to delete the references to PPOs.
3. On page 3, the following quote appears, "States are required to obtain a waiver from the Federal Government" in order to contract with a managed care organization. This statement is not correct. A majority of the Medicaid managed care plans currently in operation do not have or need waiver authority to operate. States only need a waiver of the freedom of choice provision of 1902(a)(23) of the Social Security Act (the Act) if enrollment in

the program is to be mandatory, or where some other provisions of section 1902(a) of the Act needs to be waived in order to implement the Medicaid managed care plan.

4. Also on page 3, the first bullet should be revised to read: "the elimination of the so-called "75-25" rule, which requires no more than 75 percent of the enrollees in an HMO with a comprehensive risk contract be Medicare or Medicaid eligible."
5. In the second bullet on page 3, the word "mandatory" should be inserted before "managed care" in the sixth line.
6. The words "in Pennsylvania" should be inserted after "State agency" in the first line of the third paragraph on page 7. This would clarify that the discussion regarding Oregon had ended and the next paragraph refers to requirements imposed on HealthPASS by Pennsylvania.
7. The first sentence in the last paragraph on page 10 should be revised to refer to "100 percent of the costs the State would have incurred for the services in the absence of a contract." Referring to what the State would have "paid for the services" suggests that only payments to providers are included. In fact, administrative costs incurred in making such payments are also included.
8. In the last full paragraph on page 17, (1) the word "allows" in the first line should be replaced with "expressly authorizes," and (2) the second sentence should be revised to state that the bill "also retains the States' existing authority to impose intermediate fiscal sanctions, short of termination." We believe that States currently have authority to terminate contracts. The States also currently have authority to impose intermediate sanctions short of termination. This provision appears in section 1903(m)(5) of the Act. This authority appears in S. 3191 solely because it would be recodified under that bill.
9. We would also suggest that OIG refrain from using repetitive, negative phrases such as "deliberate draining of assets" and "profiteering" in reference to a plan's owners or parent companies. There is no evidence to suggest that this is a major problem in Medicaid managed care programs. OIG's statements also ignore the Federal waiver approval and renewal process which requires States to demonstrate every 2 years that these programs are cost-effective, do not substantially impair recipients' access to services, and do not impair the quality of care provided to the recipients.

10. It should be noted that the General Accounting Office (GAO) is currently conducting an in-depth review of Medicaid managed care programs involving a number of States with a representative variety of types of programs. If OIG has not already done so, they may wish to consult with GAO on this topic.