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**REPORT TO  
THE COMMITTEE ON FINANCE 092070  
UNITED STATES SENATE**

**Better Controls Needed For  
Health Maintenance Organizations  
Under Medicaid In California** B-164031(3)

Social And Rehabilitation Service  
Department Of Health, Education, And Welfare

**BY THE COMPTROLLER GENERAL  
OF THE UNITED STATES**

~~706854~~ **092070**

SEPT. 10, 1974



COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON, D.C. 20548

B-164031(3)

*CR*

The Honorable Russell B. Long *S 4100*  
Chairman, Committee on Finance  
United States Senate

Dear Mr. Chairman:

This is our report entitled "Better Controls Needed for Health Maintenance Organizations Under Medicaid in California."

Our review was made pursuant to your request of March 6, 1973. As requested by your office, we have not obtained written comments from the Department of Health, Education, and Welfare; the State of California; or the individual Health Maintenance Organizations reviewed but we have discussed our findings with them.

*C2* As you requested, a copy of the report is being sent to the Chairman, *H 4100*  
Committee on Ways and Means, House of Representatives.

*C3* We plan no further distribution of this report unless you agree or publicly announce its contents. In this connection, we want to direct your attention to the fact that this report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions he has taken on recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the request and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. Your release of this report will enable us to send the report to the Secretary and the four committees for the purpose of setting in motion the requirements of section 236. *JK*

Sincerely yours,

*James B. Stacks*

Comptroller General  
of the United States

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ABBREVIATIONS

AFDC	aid to families with dependent children
CMS	Consolidated Medical Systems, Ltd.
DH	Department of Health
FHP	Family Health Program
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
PHP	prepaid health plan
SRS	Social and Rehabilitation Service

COMPTROLLER GENERAL'S  
REPORT TO  
THE COMMITTEE ON FINANCE  
UNITED STATES SENATE

BETTER CONTROLS NEEDED FOR  
HEALTH MAINTENANCE  
ORGANIZATIONS UNDER MEDICAID  
IN CALIFORNIA

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D I G E S T

WHY THE REVIEW WAS MADE

At the request of the Chairman, Senate Committee on Finance, GAO reviewed aspects of the expanded Health Maintenance Organization (HMO) concept under the Medicaid program in California.

GAO was asked to evaluate State procedures and actions regarding

- establishment of payment rates;
- enrollment, disenrollment, and grievance procedures; and
- HMO's capability to deliver quality services.

The Department of Health, Education, and Welfare (HEW) defines HMO, as used in Medicaid, as an organized group which provides comprehensive Medicaid services and is compensated on a predetermined per capita rate basis.

Organizations participating in California's Medicaid program (Medi-Cal), which meet the HMO definition, are referred to as prepaid health plans (PHPs) and are compensated on a monthly per capita rate basis.

FINDINGS AND CONCLUSIONS

California has been in the forefront in the development and use of the HMO concept under its Medi-Cal program.

As with any new program, a number of problems have been encountered. HEW has relied heavily on California to resolve these problems and has had very limited involvement in the program's administration.

California has passed legislation and issued regulations designed to control PHPs, but the only Federal regulation provides that HMO costs shall not exceed the cost of providing similar services on a fee-for-service basis.

Although considerable progress has been made, problems still exist in insuring that PHPs provide quality medical care to enrollees at a cost less than that of the traditional fee-for-service system.

Need for improvement  
in establishing PHP rates

A basic objective of PHPs under Medi-Cal is to reduce the cost of providing health care services to recipients. California legislation provides that PHP rates shall not exceed the amount which the State estimates would be payable for services under a fee-for-service basis.

GAO found that:

- Per capita PHP payments exceeded average fee-for-service costs during fiscal year 1972 for one of two pilot projects reviewed. The State

had anticipated significant savings on the basis of its per capita fee-for-service cost estimates.

- California's anticipated cost savings for fiscal year 1973 may not have been realized because (1) the State's estimated fee-for-service per capita costs used to negotiate PHP rates were overstated because the State underestimated reductions in medical costs due to legislative changes in Medi-Cal and (2) one PHP was awarded rates higher than the State's per capita fee-for-service estimate.
- One PHP contract was awarded for fiscal year 1974 at rates higher than the State's per capita fee-for-service estimates.
- The State does not develop per capita fee-for-service estimates on an actuarial basis which reflects differences in the need for and use of health services.
- HEW and the State have not established procedures to insure that PHP rates are negotiated in accordance with Federal and State regulations.
- The State has not adequately documented the basis for PHP rates negotiated.

As a result of its findings GAO believes that there is no insurance that the PHP program is achieving its objective of reducing Medicaid costs. (See p. 14.)

To insure that potential savings from the PHP program are realized, the State needs to refine its procedures to account for any differences in the level of medical services required by recipients who choose to enroll in a PHP as opposed to those who choose

to remain in the fee-for-service program.

Improvements needed in enrollment, disenrollment, and grievance procedures

GAO noted many cases in which recipients submitted complaints or disenrolled from PHPs because they believed the plan was misrepresented when they enrolled. GAO did not find any instances of persons being excluded from enrollment because they had major medical problems although this has been a matter of concern to the State. (See p. 26.)

Because of the heavy investment in obtaining facilities and staff to begin operations, new PHPs are interested in enrolling members as rapidly as possible. The PHPs contracted with marketing firms or employed door-to-door solicitors and reimbursed them on an incentive basis.

GAO believes these circumstances have contributed to enrollment irregularities. The State has taken several measures and implemented several regulations to control enrollment irregularities. (See pp. 21 and 22.)

GAO determined, during November 1972 through October 1973, that an average monthly recipient turnover rate of 6.2 percent occurred in the PHP program. About half of this rate represents recipients who voluntarily disenrolled; the remainder were no longer eligible for Medi-Cal.

Improvement is needed in the State's monitoring system to insure that PHPs:

- Promptly process recipient requests for disenrollment. (See p. 25.)

- Accurately report recipient reasons for disenrollment. (See pp. 24 and 25.)
- Establish appropriate grievance procedures through which complaints can be channeled. (See pp. 26 and 27.)

#### Methods used to determine quality of PHP medical services

California has established laws and regulations which require that PHP health care services be at least equivalent to the level of care provided to Medi-Cal fee-for-service recipients. One State law states that an objective of the program is to improve the quality of services rendered.

Neither HEW nor California, however, has developed standards or criteria upon which to evaluate the quality of PHP health care. The State has relied primarily on periodic evaluations by medical audit teams for insurance that PHPs are delivering high quality care. (See pp. 29 to 32.)

The State's evaluations have not been performed in sufficient depth to insure that the law's intent is being met. State regulations concerning the scope of medical audits have not been followed.

Making required onsite visits related to quality of care has had low priority with the State's PHP program managers. (See p. 30.)

In addition, the State could make better use of available data concerning PHP medical services and patients' complaints in its medical audits of PHPs. (See pp. 32 and 33.)

While most States have either limited or no Medicaid HMO programs, GAO believes HMOs will become more and

more important in State Medicaid programs, especially in light of the Health Maintenance Organization Act of 1973 which provides funds for planning and establishing HMOs.

#### RECOMMENDATIONS

The Secretary of HEW should direct the Administrator of the Social and Rehabilitation Service to develop and promulgate regulations which would:

- Provide guidance to California and other States with Medicaid HMO programs, in establishing HMO rates. Such regulations should include requirements that States document the basis for HMO rates negotiated and that these rates reflect differences in the need for and use of health services required by the population served by the HMOs compared to the general Medicaid population. (See p. 15.)
- Establish procedures for controlling HMO enrollments and disenrollments. (See p. 27.)
- Require the States to insure that all HMOs establish grievance procedures. (See p. 27.)
- Require the States to establish procedures to monitor HMO enrollment and disenrollment practices and insure proper implementation of HMO grievance procedures. (See p. 27.)
- Identify management data, such as reasons for disenrollment and use of services, which can be advantageously used by the States to monitor HMO quality of care and devise procedures to insure that accurate, standardized data is available to HMO audit teams. (See p. 34.)

--Prescribe the types of action States must take to insure that HMOs provide quality medical services. (See p. 34.)

The Secretary should also direct the Administrator to:

--Establish a Federal surveillance mechanism to insure that HMO costs do not exceed the cost of providing similar services under fee-for-service. (See p. 15.)

--Develop a model system for State monitoring of HMOs, drawing on California's experience to help other States avoid the problems California has had. (See p. 28.)

--Establish a monitoring system to insure that States comply with Social and Rehabilitation Service regulations. (See p. 28.)

#### AGENCY ACTIONS AND UNRESOLVED ISSUES

In accordance with the Committee's request, GAO did not request formal comments from HEW or the State of

California but obtained State officials' comments on the facts discussed in the report.

State officials agreed with the facts presented. However, they said the program is still in the learning stages and the various problems will be eliminated as more program experience is gained.

GAO also discussed the facts contained in the report with HEW officials and officials of the five PHPs reviewed.

On June 5, 1974, HEW published proposed regulations dealing with use of HMOs under Medicaid. These regulations are general in nature and do not address this report's specific recommendations. While these proposed regulations do represent a good starting point, GAO believes additional actions are needed.

On July 1, 1974, California initiated a new procedure for establishing HMC rates without negotiations (see p. 13). GAO plans to consider the effect of the procedure as a part of additional work now being performed for the Committee.

## CHAPTER 1

### INTRODUCTION

In a March 6, 1973, letter, the Chairman, Senate Committee on Finance, requested that we review and evaluate the expanded Health Maintenance Organization (HMO) concept under the Medicaid program in California. (See app. I.) The Chairman requested that we evaluate

- the basis used in establishing payment rates,
- enrollment procedures,
- capability to deliver services,
- arrangements for delivering services,
- the effectiveness of recipients' appeal rights,
- statistics on monthly turnover of recipients, and
- potential or actual conflict-of-interest situations between HMO principals and subcontractors and related organizations.

We agreed with the Chairman's office to

- emphasize State procedures and actions regarding the establishment of rates, enrollment, disenrollment, and grievance procedures, and HMO's capability to deliver quality services; and
- limit our review of potential or actual conflict-of-interest situations to determine whether State legislation had been enacted and what the legislation provided. (See p. 5.)

### THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in administering the program and in providing medical services to persons who are unable to pay for such care.

The services provided to Medicaid recipients vary among States. As a minimum, however, all States must provide inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing home services; home health services; early and periodic screening, diagnosis, and treatment of those under age 21; family planning services; and physician services.

The Federal Government pays from 50 to 81 percent (depending on the per capita income in the State) of the costs incurred by States in

providing medical services under Medicaid. For fiscal year 1973 the 49 States and 4 jurisdictions having Medicaid programs reported expenditures of about \$9.3 billion, of which the Federal share was about \$4.8 billion. The Federal budget for fiscal year 1974 estimates that the Federal share will be \$5.2 billion.

### Administration of Medicaid

At the Federal level, the Secretary of Health, Education, and Welfare (HEW) has delegated the responsibility for administering Medicaid to the Administrator of the Social and Rehabilitation Service (SRS). Authority to approve State plans for Medicaid has been re-delegated to SRS regional commissioners.

Under the act, each State has primary responsibility for initiating and administering its Medicaid program. The nature and scope of a State's program are contained in its State plan which, after approval by an SRS regional commissioner, provides the basis for Federal grants to the States. The regional commissioner is also responsible for determining whether the State program is being administered in accordance with Federal requirements and the State's approved plan.

### Program coverage

Medicaid authorizes health care coverage for persons entitled to public assistance under the Social Security Act. <sup>1/</sup> In addition, States can cover other persons whose incomes or other financial resources exceed State requirements to qualify for public assistance but which are not enough to pay for necessary medical care.

### Medicaid in California

The Medicaid program in California became effective March 1, 1966, and is known as Medi-Cal. The State Department of Health (DH) (formerly the Department of Health Care Services) administers the program. DH is responsible for making policy determinations, establishing fiscal and management controls, and reviewing program activities. In addition, it is responsible for approving, disapproving, or cancelling the certification of medical facilities for participation in Medi-Cal.

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<sup>1/</sup>Title I, old age assistance; part A of title IV, aid to families with dependent children (AFDC); title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, optional combined plan for other titles. Effective January 1, 1974, title XVI was revised to provide for a Supplemental Security Income program to be administered by the Social Security Administration. This revision federalized the adult public assistance programs. The implementation of the Supplemental Security Income program did not appreciably alter the criteria for Medicaid eligibility.

The cost of Medi-Cal has about doubled since the program's first year of operation. Costs for the first year--a 10-month period--were \$600 million. Fiscal year 1973 costs were about \$1.4 billion, of which the Federal Government paid about \$631 million. The average monthly Medi-Cal caseload during fiscal year 1973 was about 2,314,000, of which about 2,039,000 were public assistance recipients.

### THE HMO CONCEPT

HEW defines an HMO, as used in Medicaid, as a public or private organization which

- provides or otherwise makes available to enrolled participants comprehensive Medicaid services;
- is compensated for providing these services to enrolled participants on a predetermined periodic rate basis (e. g. a per capita monthly rate);
- provides physicians' services primarily through (1) physicians who are either employees or partners of such organizations or (2) arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis), under which all physicians and groups are provided effective incentives to avoid unnecessary or unduly costly use of medical services regardless of whether any physician is individually compensated primarily on a fee-for-service basis or otherwise;
- insures the availability, accessibility, continuity, and quality (including effective use) of comprehensive health care services through clearly identifiable focal points of legal and administrative responsibility; and
- demonstrates to the satisfaction of the State agency, proof of financial responsibility as specified under applicable State law and regulations and capability to provide comprehensive health care services, efficiently, effectively, and economically.

In California, organizations participating in Medi-Cal which meet the HMO definition are referred to as prepaid health plans (PHPs).

### BACKGROUND OF PHPs

In 1967 the California State Legislature authorized DH to undertake pilot projects to explore the feasibility of different methods of providing health care services and to determine the most efficient manner of providing such services. From 1968 through 1971, DH awarded several contracts for these projects to determine whether prepayment plans with medical group practices could provide efficient and economical health care services under Medi-Cal. The State's

preliminary evaluations of these projects indicated that such an approach was feasible and that significant cost savings could be achieved.

The Medi-Cal Reform Act, passed by California in 1971, provided for contracting with groups of medical providers to supply services on a prepaid basis to Medi-Cal recipients. The contracts stipulate that the PHP will provide or arrange for health care services for persons who voluntarily enroll, are eligible for California's public assistance programs, and reside within a geographically defined area. In turn, the State pays PHP a fixed monthly premium per enrollee for providing health care services.

The California Legislature consolidated all prepaid health-related statutes into a new chapter of the State's Welfare and Institutions Code by enacting the Waxman-Duffy Prepaid Health Plan Act, effective July 1, 1973. The Waxman-Duffy Act defined a PHP as:

"\* \* \*any carrier or association of providers of medical and health services who agree with the [California] Department of Health to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis."

Carriers, as defined by the act, include private insurance companies, medical societies, associations of insurers, nonprofit hospital service plans, county hospital systems, and profit or nonprofit persons or organizations.

The Waxman-Duffy Act specified that a PHP must provide, as a minimum, the following health care benefits:

- Physician services.
- Hospital inpatient and outpatient services.
- Laboratory and X-ray services.
- Prescription drugs.
- Skilled nursing home care.

The Legislature's intent in creating PHPs, as defined in the Waxman-Duffy Act, is to

- encourage the development of more efficient delivery of health care to Medi-Cal recipients,
- reduce the inflationary costs of health care,
- improve the quality of medical services to eligible enrollees, and
- reduce the administrative costs of operating Medi-Cal.

## Administration of PHP program

Within DH, the Health Financing System is responsible for administering the PHP program. The Director of the System has delegated the responsibility for various aspects of PHP contracting and operations to the Health Systems Program which has three sections:

- The Pilot Projects Section which develops projects to test various concepts related to PHPs and develops standards, criteria, and procedures to insure delivery of quality prepaid health care to Medical recipients.
- The PHP Development Section which reviews contract proposals to determine whether they meet departmental requirements and conducts the negotiations before awarding PHP contracts.
- The PHP Management Section which evaluates and monitors PHP operations, including medical audits, financial and reporting requirements, and enrollees' complaints.

## Status of PHP program

At the end of fiscal year 1973, 38 PHP contracts with 32 different health plans were in effect (4 plans had multiple contracts) and PHP enrollment was 172,428. Fiscal year 1973 payments to PHPs totaled over \$38 million. As of October 31, 1973, the program had expanded to 52 contracts with 43 different health plans and had an enrollment of 196,312. (See app. II.)

## Proposed regulation

On June 5, 1974, HEW published for comment proposed regulations regarding the use of HMOs under Medicaid which deal with (1) general contract provisions that would be required in HMO Medicaid contracts, (2) the overall responsibilities of States with regard to HMOs under Medicaid, and (3) Federal financial participation in Medicaid HMO programs. These proposed regulations address the problems presented in this report in a general manner but specific actions are still required.

## CONFLICT OF INTEREST

The Waxman-Duffy Prepaid Health Plan Act contains a provision that there should not be a PHP contract if any officer or employee of the State, or any member of the legislature, has any direct or indirect financial interest in any contract with the PHP or if the PHP has offered or given any such officer, employee, or member of the legislature, anything of value for influencing or attempting to influence the negotiations for approval, or renewal, of a PHP contract.

DH requires PHP contract proposals to include a "Disclaimer of Conflict of Interest;" a summary for each key number and each provider

of the plan; and brief resumes for all officers, directors, and key administrative personnel of the plan. Our review of selected PHP files at DH showed that this information was included in PHP proposal packages.

### SCOPE OF REVIEW

To evaluate the HMO concept under California's Medicaid program, we

- examined HEW's policies and procedures;
- reviewed pertinent State legislation and DH's policies and procedures;
- reviewed DH and PHP records, correspondence, reports, and contracts; and
- interviewed HEW, State, and PHP officials.

Our review was made at HEW headquarters, Washington, D. C.; at HEW's Region IX office, San Francisco, California; the Department of Health, Sacramento, California; and at five PHPs in California:

- Consolidated Medical Systems, Ltd.; Omni-Rx Health Care; and Americare Health Plan, Los Angeles County.
- Family Health Program, Orange County.
- Sacramento Foundation Community Health Plan, Sacramento, Nevada, Yolo, Placer, and El Dorado Counties.

Consolidated Medical Systems, Ltd., and Omni-Rx were included in our review at the request of the Senate Finance Committee. We selected the other PHPs to include plans of various sizes, forms of ownership, and length of time in the program. The five PHPs selected accounted for about 56 percent of the PHP enrollments in California during fiscal year 1973. Appendix III lists the number of enrollees and Medicaid payments to the five PHPs.

## CHAPTER 2

### NEED FOR IMPROVEMENT IN ESTABLISHING PHP RATES

A basic objective of the California PHP program is to reduce the costs of the Medi-Cal program. Federal regulations prohibit total payments to PHPs from exceeding amounts which would be payable for similar services on a fee-for-service basis. Payments to PHPs are made on the basis of fixed monthly per capita rates negotiated by DH officials for each contract. DH negotiations of rates are based on estimates it develops of the per capita costs of providing services on a fee-for-service basis.

We found that:

- HEW provided little guidance to the States in establishing PHP rates.
- Per capita PHP payments exceeded average fee-for-service costs during fiscal year 1972 for one of two pilot projects reviewed. The State had anticipated significant savings on the basis of its per capita fee-for-service cost estimates.
- California's estimated cost savings for fiscal year 1973 may not have been realized because (1) the State's estimated fee-for-service per capita costs used to negotiate PHP rates were overstated because the State did not accurately estimate cost reductions resulting from legislative changes in the Medi-Cal program and (2) one PHP was awarded rates higher than the State's per capita fee-for-service estimate.
- One PHP contract was awarded for fiscal year 1974 at rates higher than the State's per capita fee-for-service estimates.
- DH does not develop per capita fee-for-service estimates on an actuarial basis which reflects differences in the need for and use of health services.
- HEW and DH have not established procedures to insure that PHP rates are negotiated in accordance with Federal and State regulations.
- DH has not adequately documented the basis for PHP rates negotiated.

### LACK OF HEW GUIDANCE FOR ESTABLISHING PHP PER CAPITA RATES

Since the Medicaid program was established in 1966, medical costs have been reimbursed on the basis of either fee-for-service costs or fixed per capita rates. Since States generally used the fee-for-service

basis, HEW has not established extensive regulations and guidelines to assist States in establishing estimates for negotiating per capita rates with HMOs. In fact, the only Federal regulation pertaining to capitation arrangements requires that the cost of providing such services not exceed the cost of providing like services under fee-for-service. The proposed regulations published by HEW on June 5, 1974, do not specifically address rate-setting procedures.

The Regional Assistant Director, Program Operations, SRS region IX, told us that there has been no regional surveillance of State Medicaid PHP operations. Thus, when California embarked on its PHP pilot program in 1968 and administered it during the ensuing years, it did so with little Federal guidance or assistance. At the time we completed our fieldwork no Federal guidance had been provided to California on developing fee-for-service estimates or negotiating and awarding PHP contracts.

### PROCEDURES FOR ESTABLISHING PHP RATES NEED IMPROVEMENT

DH prepares an estimate of fee-for-service costs for each public assistance category by county to compare with proposed per capita rates submitted by PHPs. DH's goal is to use this data to negotiate per capita rates which average 10 percent less than estimated fee-for-service costs.

### Contract negotiation goals and regulations

The Medi-Cal Reform Act of 1971 and DH regulations, adopted in January 1973, require that payments to PHPs be comparable to, and potentially less than, the cost of providing similar services to comparable recipients within the same geographic area under the Medi-Cal fee-for-service program. The Waxman-Duffy Act provides that the State should determine rates annually and that payments for services on the basis of these rates not exceed the amount which the State estimates would be payable for services covered on a fee-for-service basis.

DH officials believe that delivery of health care services on a prepayment basis offers the best solution to controlling the costs of medical services. According to these officials, payment on a fee-for-service basis gives providers incentive to furnish services which may not be necessary; whereas, a prepayment system provides incentive for economy because the provider receives a fixed monthly payment for each recipient, regardless of the volume of services rendered. They believe that the prepayment approach, coupled with adequate controls to insure good quality of care, constitutes the most efficient and effective method of delivering medical care to Medi-Cal recipients.

DH officials told us that they rejected approaches to establishing rates on the basis of the contractors' actual or estimated costs because (1) State law prohibits PHP payments from exceeding the amount which the State estimates would be payable under the Medi-Cal fee-for-service system, (2) they believed that such approaches

would be more difficult and costly to administer, and (3) such approaches lack the competition of the fixed price prepayment system. DH, in order to promote competition, has not granted exclusive territorial rights to PHPs.

The Director, Health Financing Systems, told us that the State has a long term goal of awarding PHP contracts that will reduce the estimated fee-for-service costs by 10 percent. He said the State's basis for this estimated savings is (1) savings achieved during pilot programs, (2) anticipated lower administrative costs, and (3) incentives for savings inherent in the prepaid delivery system. He said that because of the newness of the program, the goal is flexible--for some contracts, the negotiated rate will provide for less than a 10-percent savings and that the savings on other contracts will be greater than 10 percent. He added, however, that the negotiated rates should never exceed DH's fee-for-service per capita estimates.

DH officials told us they do not actively solicit groups to establish PHPs. Groups become aware of the PHP program through the State's public information bulletins, which contain information on the scope and concepts of the program, and by "word-of-mouth" in the professional community. The officials stated that most PHPs are initiated by groups which have serviced Medi-Cal recipients in the past under the fee-for-service system and became aware of the PHP program through communication with DH.

The Assistant Director, Health Financing Systems, said when a proposal is received, it is analyzed by the PHP Development Section for compliance with DH requirements. If the proposal is in compliance, it is forwarded to the Rates and Fees Section for determining the acceptability of rates. Proposed rates for each of the four public assistance categories are required. The rates are compared with the State's estimates of the per capita costs of providing services on a fee-for-service basis for each public assistance category in the same county. If the proposed rates are higher than the fee-for-service per capita estimates, DH and the contractor negotiate rates that do not exceed the State's estimates. Contracts resulting from such negotiations are for a 1-year period. Renewal contracts are negotiated by the same procedure.

#### Formulation of fee-for-service estimates

Under the Medi-Cal fee-for-service program, the State contracts with private organizations, such as Blue Cross and Blue Shield, to assist in administering the program. These organizations, acting as fiscal agents for the State, review, process, and pay providers' claims for medical services rendered to Medi-Cal recipients. The State's estimate of the cost of providing services under the fee-for-service system is based on actuarial data obtained from the fiscal agents.

An internal report, prepared by the State Secretary of Health and Welfare in September 1972, states that actuarial data cannot be made

available on an up-to-date basis and that a claim does not become a part of the actuarial data until it has been processed and paid, which, in many cases, takes as long as a year. The report cited verification of medical services performed and the necessity of reprocessing incomplete billings as factors contributing to the delays in claims processing. Because more current information is unavailable, DH estimates of fee-for-service costs are based on actual costs that are as much as 2 years old.

The State prepared fee-for-service per capita estimates for fiscal year 1972 and 1974 contract negotiations. Its estimates were based on actual costs incurred primarily during fiscal years 1970 and 1972, respectively. The fiscal year 1972 per capita estimates were also used for fiscal year 1973 contract negotiations.

DH computes its per capita fee-for-service estimate in the following manner:

- The number of eligible recipients and their fee-for-service medical costs are obtained for each public assistance category for the base year.
- The fee-for-service medical costs are divided by the number of eligible recipients yielding the statewide per capita fee-for-service cost for each category for the base year.
- The statewide per capita fee-for-service costs are adjusted for inflation since the base year.
- These adjusted statewide per capita fee-for-service forecasted costs are then converted into per capita county fee-for-service cost estimates by applying countywide cost ratios for the base period to the statewide cost forecasts. The resulting countywide per capita fee-for-service cost estimates are then used to negotiate contract rates for PHPs.

We reviewed the State's procedures for estimating per capita fee-for-service costs, focusing on the documentation available for fiscal year 1974 estimates. DH used the most current data in its 1974 fee-for-service per capita estimates.

The State's system for establishing PHP rates does not provide for differences in the amount of services required, among the groups of program recipients who choose to enroll in a PHP, and among those who choose to remain in the fee-for-service system. DH regulations allow two factors which could cause average per capita costs to PHPs to be less than those of fee-for-service systems:

- PHPs can disenroll Medi-Cal recipients who have more than \$10,000 in medical expenses in 1 year.

--PHPs do not have to enroll recipients with serious medical conditions who are under a physicians' care.

To the extent that these factors exclude high-risk, high-cost recipients from PHPs and keep them in the fee-for-service system, average fee-for-service costs might be higher than average PHP costs. Because PHP rate negotiations are based on the per capita fee-for-service costs, the higher these costs are, the higher the PHP rates can be, regardless of the services provided to enrollees.

One PHP contractor has argued, however, that the recipients who choose to enroll in the PHP program tend to be those with the more severe medical problems. This contractor believes that the PHP program is more attractive to such individuals because of (1) limitations which have been placed on the use of physician services under the fee-for-service program and (2) easier access to around-the-clock physician services under the PHP program. To the extent that PHPs enroll recipients who require and use more extensive services, PHP operating costs move toward and could exceed per capita fee-for-service costs. One PHP contract has been awarded at rates higher than the States' per capita fee-for-service estimates because enrollees used the PHP's services more extensively than the average fee-for-service recipient.

The Martin E. Segal Company under a contract with HEW evaluated the establishment of PHP rates in California. Its report dated January 11, 1974, recommended on the basis of statistical data, that DH determine PHP per capita rates on an actuarial basis and reflect, by age and sex, differences in the need for and use of health services. The report stated that enrollment procedures can affect the use of services either favorably or adversely. The contract with the Company was amended to provide for additional evaluation of these matters.

As the program continues, DH will need to develop actuarial or other data to determine whether medical services provided to PHP enrollees differ significantly from those provided to fee-for-service recipients. DH should develop methodology, with HEW's technical assistance, to reflect in the PHP rate negotiation process, any differences in the need for and use of health services.

#### NEED FOR IMPROVEMENT IN NEGOTIATIONS OF PHP RATES

DH negotiation files do not contain adequate documentation to support negotiated PHP rates. We noted that DH negotiated rates which exceeded one PHP's proposed rate by 9 cents per enrollee per month; with another PHP, DH negotiated rates 11 days before computing its fee-for-service estimate, and the negotiated rate exceeded the estimate. Because of the lack of negotiation documentation, we could not determine why these actions were taken.

## Sacramento Foundation Community Health Plan

California awarded rates to the Sacramento Foundation Community Health Plan (Foundation) in fiscal year 1973 which exceeded the per capita fee-for-service estimates and resulted in payments to the Foundation which exceeded the estimates by \$406,000. In reviewing the matter further we noted that (1) the rates awarded for each of the categories were 9 cents per enrollee per month higher than those proposed by the Foundation and (2) the State awarded the Foundation a composite rate for all five counties it served. The 9 cents per enrollee per month accounted for \$24,897 of the \$406,000 in payments over fee-for-service estimates. The negotiation files did not document why the rates exceeded the fee-for-service estimates or why they were increased above the proposed level. The DH officials who reviewed the proposal could not recall why the rates were increased.

We question whether the use of a five-county composite per capita rate for each category resulted in the most realistic fee-for-service estimate. For example, 97 percent of the eligible AFDC recipients resided in the four counties with per capita fee-for-service costs lower than the composite rate. To determine the financial effect of the composite rate, we multiplied the actual enrollment in each county by the State's per capita fee-for-service estimates for each county. The State would be more insured that negotiated rates do not exceed fee-for-service estimates if separate rates are negotiated for each county.

## Consolidated Medical Systems

Consolidated Medical Systems' (CMS') fiscal year 1974 renewal contract for Los Angeles County was signed on June 25, 1973, about 11 days before DH completed computing its fiscal year 1974 fee-for-service per capita estimates. The fiscal year 1974 estimated rate for the AFDC category was lower than the rate awarded CMS. The per capita rates for the other three categories did not exceed the estimates. We were advised by DH officials that DH's Development and Rates and Fees Sections did not participate in the review of the CMS renewal proposal, as prescribed by DH's procedures, because the renewal contract was negotiated directly by the Director, Health Financing Systems.

Comparison between fiscal year 1974 per capita payment rates negotiated with CMS and DH's fiscal year 1974 fee-for-service per capita estimates, (using CMS' June 1973 enrollment levels) showed that the State might incur costs of about \$308,000 over DH's fee-for-service estimates for fiscal year 1974.

The Director, Health Financing Systems, said he could not remember the details of the negotiations, but that justification for the higher rate must have been presented to him at the time of negotiations.

New DH procedure for  
establishing PHP rates

On July 1, 1974, DH initiated a new procedure for establishing PHP rates. Under the procedure DH will reduce its county per capita fee-for-service estimates by 15 to 18 percent and publish the reduced estimates as its rates for PHPs wishing to enroll Medi-Cal recipients. The PHPs must accept the published rates if they desire to contract with DH. PHP rates are no longer negotiated.

NO INSURANCE THAT PHPs ARE SAVING MONEY

DH has not established procedures to determine whether the PHP program is achieving its objective of providing medical services at less cost than the fee-for-service system. In addition neither HEW nor DH has established procedures to insure that PHP rates are established in accordance with Federal and State regulations. Our comparison of contract payments to two PHPs for fiscal year 1972 and all California PHPs for fiscal year 1973 indicates that the PHP program may not be saving money as projected by DH and might be more costly than the fee-for-service program.

During fiscal year 1972, DH had contracts with six pilot projects in California to provide medical services on an experimental prepaid basis to Medi-Cal recipients who voluntarily enrolled. For the two projects which had terminated their pilot status as of July 1, 1972--CMS and Family Health Program (FHP), in Los Angeles County--we compared total contract payments with DH's fee-for-service estimates and with actual fiscal year 1972 fee-for-service costs. The other four pilot projects had either withdrawn from the program at the time of our fieldwork or were still operating as pilot projects.

Comparison of the two projects' actual contract costs with DH's fee-for-service estimates indicated that the State expected to save about \$1.2 million on the CMS contract and about \$351,000 on the FHP contract. Comparison of contract payments to the actual fee-for-service costs, however indicated that the State saved about \$255,000 through the CMS contract and that State payments to FHP exceeded the fee-for-service costs by about \$151,000.

DH budget officials told us that their estimated fee-for-service costs for fiscal year 1972 were overstated because they underestimated the reductions in fee-for-service medical costs which would result from passage of the Medi-Cal Reform Act which became effective in October 1971. This act limited the use of prescription drugs, physicians, hospital in-patient service, and other medical services. The officials explained that the impact of these limits on the costs of the fee-for-service program could only be guessed at the time the estimates were made.

During fiscal year 1973, DH negotiated contract rates using the same fee-for-service per capita estimates used in negotiating fiscal year 1972

rates. These estimates had been developed from fiscal year 1970 actual fee-for-service costs. The contract costs for fiscal year 1973 for the total PHP program were about \$4.1 million less than the State had estimated the costs would have been under the 1972 estimated fee-for-service rates.

DH budget officials commented that because the fee-for-service costs were overestimated for fiscal year 1972, new estimates were not computed for fiscal year 1973. Instead, the previous year's estimates, unadjusted, were used as the basis for awarding PHP contracts in fiscal year 1973. In addition, the officials stated that if new estimates had been developed, using the latest fee-for-service costs available, which would have been 1971 data, these estimates would also have been overstated because the figures would not have reflected the cost impact of the Medi-Cal Reform Act.

We could not compare PHP payments and actual fee-for-service costs for fiscal year 1973 because actual costs were not available at the time of our fieldwork. To attempt to determine if the PHP program had achieved savings during fiscal year 1973, we recomputed estimated 1973 fee-for-service costs using fiscal year 1972 actual cost data and inflation factors provided by the DH Budget Section. This comparison showed that the costs of the PHP program in California for fiscal year 1973 might have exceeded estimated fee-for-service costs by about \$471,000. The increased PHP costs were associated with one plan, the Foundation.

## CONCLUSIONS

The only guidance HEW Has provided to States for developing per capita PHP rates is the requirement that the per capita rate be less than the fee-for-service cost. In addition, HEW has not established procedures or controls to insure that PHP rates are established in compliance with Federal regulations. California did establish procedures to develop and negotiate PHP rates, but did not establish procedures to determine whether the PHP program is less costly than the fee-for-service program. Our review indicates that California's PHP program may be more costly than the State's fee-for-service program.

DH computes its estimate of fee-for service costs which it uses in negotiating PHP rates, by including all Medicaid recipients using the fee-for-service system. This method does not take into account differences in the need for and use of health services in the population served by PHPs compared to the general Medicaid population. The establishment of PHP rates should account for differences in the level of medical services required by PHP enrollees compared to fee-for-service recipients. HEW should require the States to document the basis for the HMO (PHP) rates negotiated. There has been no insurance that the PHP program is achieving its objectives of reducing Medicaid costs.

## RECOMMENDATIONS

We recommend that the Secretary of HEW, direct the Administrator, SRS, to develop regulations which would provide guidance to California and other States with Medicaid HMO (PHP) programs, in establishing HMO rates. These regulations should require that States document the basis for the HMO rates negotiated and that these rates reflect differences in the need for and use of the health services required by the population served by HMOs as compared to the general Medicaid population. We further recommend that the Secretary direct the Administrator to establish a Federal surveillance mechanism to insure that HMO costs do not exceed the cost of providing similar services under fee-for-service.

## CHAPTER 3

### IMPROVEMENTS NEEDED IN ENROLLMENT,

### DISENROLLMENT, AND GRIEVANCE PROCEDURES

HEW has not provided guidance or issued regulations to assist States in controlling the enrollment and disenrollment of persons in the Medicaid HMO program. DH established its own procedures; however, some of the procedures were not established until well after the program was underway and some had not been fully implemented at the time of our fieldwork.

Since PHP operations began, the State has received numerous complaints charging that deception and misrepresentation were used to induce persons to enroll in PHPs. Also, State officials have been concerned that the economic incentives of PHPs might cause them to avoid enrolling persons likely to have major health problems.

PHP and State officials advised us that enrollment irregularities have occurred and have stemmed mainly from the fact that PHPs must obtain large numbers of enrollees over a short time to minimize losses during the startup period. The practice of paying economic incentives to PHP enrollers--bonuses for each person enrolled--possibly increases the chance of enrollment irregularities.

Recently, DH has taken action which should help to control PHP enrollment irregularities. During November 1972 through October 1973, the turnover rate for the PHP program averaged 6.2 percent per month. About half of the enrollees voluntarily disenrolled and the remainder were involuntarily disenrolled because they were no longer eligible for Medi-Cal.

We did not find any instances of the selective disenrollment of persons with high medical expenditures. Many recipients submitted complaints or disenrolled from PHPs because they believed the plan was misrepresented to them at the time they enrolled. DH has not received any complaints from individuals claiming they were denied the opportunity to enroll in a PHP. Also it has waived State regulations specifying that enrollment may not be terminated for 1 year except for loss of eligibility or good cause and is allowing most dissatisfied recipients to disenroll.

Our review at DH also showed that improvement is needed in the State's monitoring system to insure that PHPs

- process recipients' requests for disenrollment promptly,
- accurately report recipients' reasons for disenrollment, and
- establish appropriate grievance procedures through which complaints can be channeled.

## ENROLLMENT AND DISENROLLMENT LEGISLATION AND REGULATIONS

The Medi-Cal Reform Act of 1971 requires that Medi-Cal recipients be given the choice of how they receive health care benefits. The Waxman-Duffy Act requires that enrollment in PHPs be voluntary and prohibits the use of false advertising to induce enrollments. The intent is that Medi-Cal recipients be able to choose between competing health care delivery systems.

The State's guidelines for preparing proposals, the standard PHP contract, and DH administrative regulations describe (1) acceptable methods of marketing, (2) types of materials and procedures allowable in marketing the PHP program, and (3) the types of persons eligible for the PHP program. DH regulations also state that the PHP is responsible for the marketing activities related to its plan, even through advance approval of marketing materials and procedures by DH is required. The PHP is to (1) insure that marketing representations clearly describe the benefits and limitations of the plan and (2) independently verify applications submitted by marketing representatives and insure the correctness of the information presented to applicants. DH regulations also state that marketing representatives shall not in any way misrepresent themselves, the plan, or the Medi-Cal program.

DH regulations prohibit PHPs or their marketing representatives from using any procedure to identify potentially eligible enrollees with medical or psychiatric problems in order to exclude them from enrollment other than for medical conditions specifically excluded from coverage by the contract.

DH regulations state that, once a Medi-Cal recipient is enrolled in a PHP, the enrollment may not be terminated for a minimum of 1 year, except for loss of eligibility or good cause as determined by the DH Director. Disenrollment may be approved when there is reasonable cause, such as when:

- Delivery of health care services to an enrollee exceeds \$10,000 in a 12-month enrollment period.
- An enrollee has transportation difficulties in gaining access to health care services.
- An enrollee moves outside the PHP service area.
- A PHP violates marketing procedures when enrolling the recipient.
- The enrollee has a preexisting medical condition for which he is being specifically treated for by a provider not participating in the PHP.

## MISREPRESENTATION AND OTHER ENROLLMENT IRREGULARITIES

From the inception of the PHP program, charges were made concerning misrepresentation and other irregularities in the enrollment process. These charges were presented in newspaper articles, enrollees' letters, disenrollment forms, and public hearings.

We reviewed a sample of 35 letters DH's Los Angeles office received during the first 4 months of 1973, and we noted that 12 persons claimed misrepresentation on the part of enrollers. For example:

- The enrollee would not be restricted to the PHP's doctors, but could go to any doctor in California.
- The enrollee could keep his Medi-Cal fee-for-service card.
- The enroller claimed to be a social worker and told the enrollee that he must join a PHP or lose his welfare benefits.

We also noted eight cases in which persons claimed that enrollment forms were signed by someone else.

In a DH memorandum, dated February 22, 1973, the Administrator of DH's Los Angeles office stated that on the basis of 100 interviews with PHP enrollees who wished to disenroll, the primary source of discontent was the over-selling of PHP services, and false, misleading, or incomplete information given during the enroller's visit.

Furthermore, DH's data for all PHPs, except the Foundation, showed that during March through October 1973 about 6 percent of the enrollees disenrolled because the plan had been misrepresented. The Foundation had a 0.3 percent disenrollment rate for misrepresentation.

In testimony at public hearings held in January 1973 by a nonprofit group representing consumers and medical providers in Los Angeles County, it was stated that enrollers had misrepresented themselves. Cases were discussed in which it was charged that enrollers dressed in white uniforms to give the impression that they were representing the medical profession and that they had also given the impression that they were welfare department personnel. In other cases, it was charged that persons were left with the impression that they had to join a PHP or lose their Medi-Cal benefits, or that after joining the PHP, they could continue to see the physician they were presently seeing.

### Initial costs and break-even points for PHPs

Considerable initial investment in staff, facilities, and equipment is necessary to establish a PHP. Sufficient enrollments must be obtained to generate revenues to provide health care services and to meet financial obligations. We believe that the PHPs' need to enroll large numbers of clients quickly has contributed to enrollment irregularities.

The Director of Omni-Rx stated that if an organization is new, the initial investment in obtaining facilities and staff to begin operation is substantial. He said the number of enrollees needed to break even is difficult to determine because of many variables, such as the proposed size of the PHP, the number of non-Medi-Cal contracts, and the existence of an established fee-for-service practice.

He also said that, since Omni-Rx has agreements to provide medical services to persons from other organizations, it is difficult to separate the medical services provided to Medi-Cal patients. He stated that Omni-Rx has about 4,500 enrollees under its PHP contract but had not yet realized any profit.

The need for large, early enrollments was also discussed in a recent article written by two authorities involved in a study of HMOs. <sup>1/</sup> They stated that, since every HMO is different, they were unwilling to set an absolute break-even point, but felt that at least 10,000 enrollees, in most cases, would be needed to insure the HMO's ability to provide comprehensive health benefits. To make a profit, new HMOs need to enroll from 15,000 to 30,000 subscribers in the first 2 to 3 years of operation.

Methods of enrolling recipients

Our review of the five PHPs showed that three used their own marketing organizations to enroll recipients, while two used marketing firms. The primary method used to enroll recipients was door-to-door solicitation, although other methods were used as shown below.

<u>PHP</u>	<u>Type of marketing organization</u>	<u>Main enrollment methods</u>
CMS	In-house	Door-to-door solicitation and explaining program to CMS' Medi-Cal fee-for-service patients.
FHP	In-house	Door-to-door solicitation and mailing brochures through DH.
Omni-Rx	Contract firm	Door-to-door solicitation.
Americare	Contract firm	Door-to-door solicitation, presentations at community functions, and mailing brochures through DH.

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<sup>1/</sup> Paul M. Ellwood, Jr., MD, and Michael E. Hubert, "Health Care: Should Industry Buy It or Sell It?" Harvard Business Review, (July-August 1973).

<u>PHP</u>	<u>Type of marketing organization</u>	<u>Main enrollment methods</u>
Foundation	In-house	Participating practitioners encouraging their Medi-Cal fee-for-service patients to join the plan; mailing brochures through DH; enrollment and information booths at welfare offices, food stamp outlets, and food commodity outlets; and door-to-door solicitation.

Marketing personnel of the four PHPs which mainly used door-to-door solicitation stated that their PHPs were in southern California areas which have boundaries that overlap other PHPs. An example of this was cited in an August 1973 State Auditor General report--in one area in Los Angeles County at least 13 organizations were competing for PHP enrollments. The marketing personnel added that, because of this competitive atmosphere, the most effective technique for enrolling Medi-Cal recipients is door-to-door solicitation. Also, since PHPs do not have the names of eligible Medi-Cal recipients (such information is confidential) door-to-door solicitation is necessary. The marketing representatives stated that solicitation is geared to low-income areas with a high concentration of welfare recipients.

The marketing officials stated that training programs have been implemented to provide enrollers with the necessary knowledge of the plan and the techniques that should be used in soliciting enrollees. We noted, however, that the methods and degree of training varied.

A representative of Americare Health Plan's marketing firm, responsible for training the enrollers, stated that enrollers were not given a standard presentation, but did receive consultation on how to approach potential PHP enrollees. They were also provided information on PHP's operations, services, and medical providers. At FHP, which has an in-house marketing operation, new enrollers were given a 4-hour marketing briefing, shown a film on how to sign potential enrollees, and then accompanied experienced enrollers for 1 week to observe field techniques.

Each of the four southern California PHPs paid its enrollers a guaranteed salary plus a bonus for each eligible family or individual contract.

The Foundation is the only PHP servicing its area and does not rely completely on door-to-door solicitation. It does not provide medical services but operates mainly as a fiscal intermediary; that is, it receives capitation payments from the State and pays physicians and other providers

of services. Many physicians participating in the Foundation were fee-for-service providers before the Foundation's entry into the PHP program and encouraged their patients to enroll. Therefore, many of the Foundation's enrollees continue to go to the same doctor.

The Foundation's Marketing Director said when they first began marketing the plan, DH mailed the Foundation's marketing material to eligible Medi-Cal recipients in the service area. The recipients were provided a stamped preaddressed card which was to be returned to the Foundation if they were interested in further information. The Marketing Director stated that, as a result of the first two mailings, 9,000 persons enrolled in the plan.

#### DH actions to control enrollment irregularities

DH officials agreed that irregular enrollment practices have occurred and recently instituted an aggressive program to bring PHPs in full compliance with laws and regulations. The DH Marketing Analyst stated that, from the inception of the PHP program, DH has tried to prevent enrollment irregularities by (1) subjecting all promotional materials to DH approval, (2) briefing PHP marketing representatives on acceptable enrollment conduct, and (3) observing enrollment procedures during onsite visits.

Continued adverse publicity about PHP marketing activities prompted DH, in February 1973, to open an office in Los Angeles to investigate complaints relating to enrollment practices. The office directed its efforts at specific complaints from individual enrollees, welfare rights organizations, and other sources. However, no efforts were made to evaluate, overall, the enrollment practices of specific PHPs or impose sanctions on PHPs that did not comply with DH regulations.

Despite DH's attempts to alleviate abuses, charges concerning misrepresentation by door-to-door enrollers continued. In July 1973-- following much adverse publicity associated with actions taken by the Los Angeles and San Diego County District Attorneys' offices involving charges of fraudulent enrollments and violations of State laws against unfair business practices and false advertising--DH ordered a moratorium on door-to-door solicitation in San Diego County, and in September 1973, issued a similar order for Los Angeles and Orange counties. In all, 38 PHPs were affected. The moratorium was to continue until DH developed a better way to regulate solicitation.

DH established criteria and procedures for reinstating door-to-door solicitation. In a letter, dated September 14, 1973, DH requested the PHPs affected by the moratorium to submit certain documentation for evaluation, including

- information on the PHP enrollers,
- the enroller training and examination program,

--the standard enroller presentation, and

--PHP's plans for 100-percent verification of new enrollees' understanding of the plan.

PHPs were also required to have all their enrollers attend a special DH briefing. A DH official told us that 32 of the 38 affected PHPs had their door-to-door solicitation privileges reinstated within 1 month.

In October 1973 DH implemented additional steps to control door-to-door solicitation. Twenty-three additional persons were assigned to Los Angeles and San Diego to perform 100-percent verification of PHP enrollments. The verifications covered all new enrollments in Los Angeles, Orange, and San Diego counties. Enrollments in these three counties represent about about 90 percent of total new statewide enrollments. DH documentation shows that as of January 24, 1974, 15,782 enrollment contracts were approved and 753 were disapproved through DH's verification. The contracts were disapproved because (1) individuals moved, (2) individuals misunderstood the plan's services, or (3) enrollers possibly misrepresented the plan. A DH official stated that when indications of misrepresentation were found, PHPs were notified and actions were taken against the individual enrollers, including firing them.

#### PHP enrollment control procedures

Officials from the four PHPs we reviewed in southern California stated that, upon learning of enrollment irregularities, they established procedures to reduce them. CMS officials advised us that in March 1973, CMS personnel began contracting new enrollees on a spot-check basis to determine whether enrollers had presented the plan correctly and whether new enrollees fully understood the plan's services. In September 1973 CMS began making these verifications for all new enrollees. A CMS official said if a number of cases involving misrepresentation could be associated with a particular enroller, that individual would be counseled by his supervisor, and if problems continued, the enroller would be released. Documentation showed that, during August 1972 through April 1973, CMS terminated the employment of 11 enrollers for misrepresentation.

FHP has less formal procedures than CMS to reduce enrollment irregularities. The FHP Marketing Coordinator said the enroller is told when an enrollment complaint is received and is counseled on how to avoid such complaints in the future.

Representatives from Omni-Rx and Americare said they contacted new enrollees who were signed into the plans by their outside marketing firms. The Omni-Rx Coordinator stated that they attempted to contact about 20 percent of AFDC enrollees and the majority of the other enrollees.

A representative of Omni-Rx's marketing firm said the firm followed up on all enrollments by having enrollers' supervisors visit each enrollee on the day of enrollment or the next day.

Americare officials told us that they contacted all new enrollees before submitting their enrollment applications to DH.

### HIGH RATE OF DISENROLLMENTS

Two types of disenrollment occur in the PHP program. Involuntary disenrollment occurs when a recipient loses his State Medi-Cal eligibility. Voluntary disenrollment occurs when a recipient disenrolls from the PHP program and returns to the Medi-Cal fee-for-service system.

DH began compiling disenrollment statistics in November 1972. During November 1972 through October 1973, the average monthly rate for voluntary disenrollment for all PHPs, except the Foundation, was 3.2 percent. For the four southern California PHPs we reviewed, the average monthly rate for voluntary disenrollment was 3.0 percent. The Foundation had the lowest monthly voluntary disenrollment rate of 0.3 percent. The lower rate at the Foundation could possibly be attributable to the plan's organizational structure which allows most PHP enrollees to remain with their family physician.

A DH official told us that, because of the many complaints concerning misrepresentation, DH decided to approve most disenrollment requests rather than to have dissatisfied enrollees in a PHP.

The disenrollment process is carried out through the PHP. The enrollee lists his reason(s) for disenrolling on the back of the disenrollment form. The PHP lists on the front of the form the enrollees reason for disenrolling and submits the form to DH for final approval. PHP contracts require that the PHP process the disenrollment without delay--no more than 5 working days. If DH receives a disenrollment form by the 15th of the month, the recipient is disenrolled effective the 1st of the following month and is reissued his Medi-Cal card which enables him to participate in the fee-for-service program.

In March 1973, DH expanded its statistical data collection effort to include the reasons reported by the PHPs for voluntary disenrollments from the plans. DH officials told us these statistics would help them identify problems that might require closer surveillance. From March through October 1973, DH approved about 42,000 voluntary disenrollments and statistics were analyzed for 78 percent. The major reasons cited for leaving the PHPs were:

	<u>Percent</u>
Patient wishes own doctor	31
Lack of transportation to health facility	17
Dissatisfaction with plan's service	14
Patient moved from plan's service area	10
Mistaken enrollment (misrepresentation)	6
Other	<u>a/ 22</u>
Total	<u><u>100</u></u>

a/ Includes problems, such as long waits at clinics and difficulties in obtaining appointments or emergency service.

The preceding data is of limited usefulness because (1) recipients often cited reasons they felt would be readily accepted rather than the actual reasons and (2) PHPs did not always accurately report the reasons given by the recipients.

Inaccurate reporting of recipients' and PHPs' reasons for disenrollments

In January 1973 DH established procedures to conduct, on a sample basis, telephone surveys of disenrolled recipients to verify the reasons for disenrollment. The Chief, Management Section, stated that DH has established a policy of contacting 100 persons each month who submitted disenrollment forms.

As of October 1973, DH had made two surveys. In the first, for February and March 1973 disenrollments, DH contacted 41 persons. In the second, for April 1973 disenrollments, DH contacted 100 persons. The results of both surveys showed that, in many cases, persons' reasons for disenrolling were different from those they put on the back of their disenrollment forms, as shown below:

<u>Reasons for disenrollment</u>	<u>Percentage</u>	
	<u>On disenrollment form</u>	<u>In phone survey</u>
Patient wishes own doctor	51	9
Lack of transportation to health facility	8	10
Dissatisfaction with plan's services	9	24
Mistaken enrollment (misrepresentation)	2	26
Patient moved from plan's service area	1	6
Critical of plan's emergency service	1	6
Long wait at clinics	0	7
Difficulty in getting appointments	0	3
Other	<u>28</u>	<u>9</u>
	<u>100</u>	<u>100</u>

The Deputy Director, Health Financing Systems, and the Chief, Management Section, commented that dissatisfied recipients often write reasons for disenrollment that they know the PHP and DH will approve rather than their real reason.

We made a telephone survey of former PHP enrollees which showed similar results. The reasons given by persons we contacted did not always agree with information on the forms. We randomly selected 20 forms for persons who disenrolled from May through July 1973 from the four PHPs

reviewed in southern California. Of the 20 contacts, 11 gave different and/or additional reasons than those stated on the disenrollment forms.

Similarly, our review of a sample of 20 PHP disenrollment forms prepared by FHP officials during January through May 1973, showed that on 12 of the disenrollment forms sent to DH, the reasons cited on the front of the form by FHP officials and used by DH in its monthly reports did not accurately reflect the reasons cited by recipients on the back of the forms or in letters. For example, we found six cases where the disenrollment forms sent to DH stated "prefer own doctor" or "not satisfied with doctor/patient relationship" as the reason for disenrollment. However, individuals cited different and/or additional reasons on sheets attached to the forms, such as "clinic too far from residence," "doctor would not prescribe drugs," "the physician's diagnosis was incorrect," and "not happy with the emergency service."

#### Timely submission of disenrollment forms to DH

A DH representative, testifying at public hearings held by a nonprofit organization representing consumer and medical providers in Los Angeles County, indicated that some PHPs may be delaying the processing of disenrollment forms "to hold onto the patient for a little bit longer." In this regard, DH documentation showed that, between March and October 1973, 22 PHPs had submitted 1,430 disenrollment requests at least 1 month after the enrollees filled them out. Therefore, PHPs might be receiving capitation payments from the State for persons who believe they have disenrolled.

Four of the five PHPs that we reviewed generally submitted disenrollment forms to DH promptly. Our review at CMS showed that there was some delay in its submission of the forms. For example, during a 12-week period, CMS submitted about 275 requests for disenrollment (about 3 percent of those submitted) at least 1 month late. As a result, CMS continued to receive payments for enrollees at least 1 month longer than if the forms had been promptly submitted to DH.

When we brought this situation to the attention of CMS officials, they sent an internal memorandum to all CMS facilities directing that all disenrollment requests be processed promptly.

The Chief, Management Section, stated that DH recognizes late submission of disenrollment forms as a major problem. DH has sent letters to PHPs urging them to promptly forward disenrollment forms, and it had previously suspended enrollments at one PHP because of its late submission of forms. In another case, DH had also sent a letter to a PHP stating that further violations could result in suspension of further enrollments, a withholding of all or part of the PHP payments, or termination of the PHP contract.

### Selective disenrollments

The Assistant Chief, Management Section, stated that even though DH has suspected PHPs of selectively disenrolling recipients whose medical expenses are unusually high, such cases are difficult to identify and prove. He told us that PHPs have responded to charges of selective disenrollment by stating that the enrollee had a preexisting medical condition which required specific treatment and that the PHP did not want to disrupt a previously established doctor-patient relationship.

We did not identify any specific instances of selective disenrollment. However, a DH memorandum described two cases of possible selective disenrollment at one PHP in May 1973. The Chief, Management Section, informed us that DH suspended this PHP's enrollment privileges until legal proceedings were completed. However, DH could not document this. The memorandum stated that this was the first case of a potential selective disenrollment found by DH. In December 1973, the Chief of the PHP Management Section told us that the Los Angeles County District Attorney was studying possible legal action against the same PHP because of selective disenrollment.

### GRIEVANCE PROCEDURES NOT ADEQUATELY IMPLEMENTED OR MONITORED

The standard PHP contract and DH regulations, issued in January 1973, require PHPs to establish enrollee grievance procedures.

The regulations require that PHP grievance procedures be approved by DH before approval of the proposed contract. DH officials informed us, however, that PHPs are primarily responsible for implementing complaint and grievance procedures, and that DH has not established monitoring procedures to determine whether PHPs' procedures are operating effectively.

Two DH officials responsible for monitoring PHPs stated that most complaints have been resolved by PHPs, but that when complaints have not been resolved, enrollees have frequently complained to welfare workers, welfare rights organizations, or directly to DH. When DH receives complaints, DH officials document both the PHP's and the enrollee's positions. The DH program benefits representative also stated that DH may impose sanctions, such as curtailment of enrollments, on those PHPs on which DH receives numerous complaints.

Complaint and grievance procedures at the five PHPs included in our review varied. For example, CMS had written procedures which detailed actions to be taken by enrollees and organizational units responsible for handling complaints. CMS documented the action taken to resolve the complaints and the outcome.

CMS had released medical personnel who were at fault in an enrollee's grievance. FHP and Americare also had written procedures to handle enrollee complaints, but we noted that these PHPs were not complying with their procedures.

At the time of our fieldwork, Omni-Rx was in the process of developing complaint and grievance procedures to meet DH requirements, and the Foundation had not developed formal grievance procedures.

### CONCLUSIONS

Public hearings have indicated, and DH and PHP personnel have agreed, that enrollment abuses have occurred. The need of newly established PHPs to quickly enroll large numbers of recipients to cover fixed costs and remain solvent, and the practice of PHPs paying economic incentives to marketing representatives to enroll as many people as possible may contribute to the number of abuses. DH has taken action to alleviate these problems, such as requiring the verification of all enrollment forms.

PHPs have experienced high disenrollment rates, partially resulting from enrollment irregularities, and have not always submitted disenrollment forms promptly. DH has developed procedures to monitor disenrollments, such as sample surveys to determine the accuracy of the reasons for disenrollment as reported by PHPs. However, these procedures have not been fully implemented.

DH has not required PHPs to have an adequate system for handling enrollee grievances. Thus, procedures varied widely among PHPs, and some PHPs had no established formal grievance systems. PHPs should have adequate grievance systems to protect the rights of enrollees; and, therefore, DH should increase its monitoring to insure that PHPs do have adequate grievance systems.

While most States have either limited or no Medicaid HMO programs, HMOs will become more and more important in State Medicaid programs, especially in light of the Health Maintenance Organization Act of 1973 which provides funds for planning and establishing HMOs.

### RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator, SRS, to develop and promulgate regulations which would

- establish procedures for controlling HMO enrollments and disenrollments,
- require the States to insure that all HMOs establish grievance procedures, and
- require the States to establish procedures to monitor HMO enrollment and disenrollment practices and insure the proper implementation of HMO grievance procedures.

The Secretary should also direct the Administrator to

- develop a model system for State monitoring of HMOs, drawing on California's experience, to help other States avoid the problems California has had; and
- establish a monitoring system to insure that States comply with SRS regulations.

CHAPTER 4  
METHODS USED TO DETERMINE  
QUALITY OF PHP MEDICAL SERVICES

Since the PHP program began, there have been charges of poor quality of care from enrollees. Therefore, the assessment and careful monitoring of PHP services are important to the success of the program.

The Medi-Cal Reform Act states that PHP health care services be at least equivalent to the level of care provided to Medi-Cal fee-for-service recipients. The Waxman-Duffy Act states that one objective of the PHP program is to improve the quality of medical services rendered to eligible enrollees. This act requires DH to conduct periodic onsite reviews to determine the level and quality of care, the necessity for services rendered, and the appropriateness of PHP services.

DH officials stated that medical evaluations are important because the incentives for minimizing costs in PHPs increase the risk of patients being provided less than optimal care. Since neither HEW nor the State has developed widely accepted quality-of-care standards for PHP operations, DH officials informed us that State medical audit conclusions are based mainly on the impressions and judgments of physicians conducting the audits.

Our review of the medical audit reports for five PHPs indicates that DH evaluations were not performed in sufficient depth to determine whether the PHP program has provided quality medical services to enrollees.

DH has not evaluated, or made available to medical audit teams, data it obtained from PHPs regarding patient visits, services provided, number and length of hospital stays, and patient complaints. Such data would assist medical audit teams in identifying potential weaknesses and recommending improvements in PHP medical services.

Enrollee grievances of PHP services have been made known through public hearings for PHP contract renewals; complaint letters sent to PHP consumer organizations, including welfare rights organizations; and comments on disenrollment forms.

LIMITED EVALUATIONS OF  
MEDICAL SERVICES' ADEQUACY

DH performs preaward and postaward evaluations of the adequacy of PHP medical services. DH contract managers also perform on-site evaluations of PHP management capabilities.

We reviewed DH's medical audit reports for the five PHPs selected for review. It appeared that the depth of the audits was limited, as evidenced by the brief time required to make the audits and the relatively few medical charts examined. Also, the audits performed did not cover all areas required by DH regulations. DH officials said onsite visits by DH contract managers to PHP facilities had a low priority.

Before awarding a PHP contract, DH is required to

- evaluate the PHP's proposal for providing the required Medi-Cal benefits; procedures for emergency services; and the system for performance, monitoring, and health care evaluation;
- evaluate the organizational structure of the PHP;
- perform background checks on the PHP's professional personnel, including status with the appropriate State licensing board; and
- perform an onsite inspection of the PHP's facilities, including accessibility to public transportation and cleanliness, and to insure that proposed services can be provided at an acceptable level.

DH performed preaward evaluations for the five PHPs reviewed.

After a contract is signed, the PHP Management Section is responsible for monitoring the PHP's operations to insure that the terms of the contract are followed and to resolve any problems. This is done through periodic onsite visits by DH contract managers and medical audits.

The onsite visits consist of checking the continuing availability of services, average waiting time, and time required to obtain an appointment. Also, unannounced visits are made to check the availability of 24-hour emergency service. Each contract manager in the Management Section is assigned about five PHPs to monitor.

Management Section officials agreed that onsite visits have not been made as often as required and, because of staff shortages and continual reassignments of contract managers to different PHPs, onsite visits had a low priority in a contract manager's workload. They told us that DH plans to conduct about three onsite visits each year for each PHP, and that the visits will be made before the medical audits or when PHP deficiencies are identified. If these actions are done, they should improve DH's monitoring of PHP operations.

DH procedures require that medical audits be conducted at all PHP primary facilities generally 3 months after the PHP begins its operations and every 6 months thereafter. These audits include reviews of (1) the physical facilities and equipment; (2) the system for patient care; (3) a sample of enrollee medical records; (4) the peer

review system and reports; and (5) the grievances relating to medical care, including their disposition. The evaluation team, which conducts the audits, consists of a physician, a dentist, a pharmacist, a registered nurse, and a field representative.

DH had not conducted the medical audits as often as prescribed by the DH regulations, mainly because of a lack of evaluators. However, in December 1973, the Chief, Medical Audits Section, informed us that the problem of obtaining a sufficient number of evaluators no longer existed. He said that effective July 1, 1973, DH reorganized and the responsibility for medical audits was assigned to the Medical Audits Section, which has six physicians and six field representatives to evaluate PHP services when scheduled audits become due. He commented that field representatives, who are trained paramedics, make the detailed inspections while the physicians review their area of specialty. The Chief also said that the staffing level in December 1973 was sufficient to make two medical audits a year at each PHP.

In regard to the depth of medical audits, we noted that all of the required audit procedures were not accomplished during the audit and that the length of time of the audits was limited. For example, the medical audit reports of the four PHPs we reviewed in southern California showed that the average length of time taken by the evaluation team to make audits ranged from 1/2 to 2 days at each PHP facility. An evaluation team made a 2-day audit at only 1 of 23 CMS facilities in January 1973. During the audit, the team

- observed the medical facilities and equipment;
- obtained information on accessibility of transportation to clinics and the composition of the professional staff;
- reviewed appointment, emergency care, and peer review procedures; and
- checked about 60 medical charts.

A total of 38,571 outpatient visits were made to CMS facilities during the 3-month period between the January 1973 audit and a previous audit.

The audit team did not review enrollee grievances as required by regulations. Furthermore, none of the audits of the five PHPs in our review evaluated enrollees' grievances relating to medical care or their disposition.

Enrollees' medical records were not checked during the only medical audit made at Omni-Rx during its first contract year; thus, DH had no insurance that the PHP's recordkeeping was adequate or that appropriate medical services were provided.

A physician from the Medical Audits Section informed us that he believes 1 day is sufficient to evaluate PHP medical services and that the additional costs incurred in extending an audit could not be justified because the additional data obtained normally does not change the audit

conclusions. He also stated that the degree of audit and conclusions reached are based on the evaluators' professional judgment. The evaluators can often make judgments on the quality of PHP services by walking through the facilities, reviewing the procedures, and talking to the physicians.

The Chief agreed that all required audit areas were not reviewed and that the evaluators' judgments determine the degree of audit to be made. He added that, if an evaluator can determine the quality of PHP services without reviewing the grievance system, he can omit this audit area from his review. He also said that when checking enrollees' medical records, an evaluator selects a minimum number of records and increases his selection if recordkeeping deficiencies are noted or if methods of treatment are questionable.

Since there are no generally accepted procedures for conducting medical audits, we cannot determine the adequacy of DH's medical audits. However, considering the amount of program activity at each PHP and the questions which have arisen about the quality of services provided, more detailed medical audits are probably warranted.

#### DH SHOULD USE MANAGEMENT INFORMATION IN EVALUATING PHP MEDICAL SERVICES

DH officials told us that medical quality standards, which can be broadly applied for meaningful comparisons among PHPs, do not exist; therefore, in evaluating the quality of PHP medical services, medical audits must be used in conjunction with other information, such as use of medical services and patient satisfaction.

The PHP Management Section receives cost reports and statistical data on how often PHP services are provided, as well as information on reasons for recipient disenrollments and complaints regarding quality of services. The Management Section had not analyzed the data nor transmitted this information to the medical evaluation teams for use in making audits; this information would afford the evaluation team better insight on PHP operations and enable it to direct audits toward areas needing attention.

The economics of a PHP operation warrant that monitoring be directed toward the frequency at which various medical services are provided. Whereas a fee-for-service provider might attempt to increase his income through the overuse of medical services, PHPs have a reverse economic incentive which may result in minimizing costs. Therefore, a major concern in monitoring a PHP's activities is determining whether services are underused, resulting in lower quality health care.

DH will have to standardize and analyze data submitted by PHPs to make it more useful. The Chief, Medical Audits Section, stated that there is a need to develop better data to aid the medical audit teams in their evaluations. He advised us that DH is developing

standardized criteria for new monthly data reports. In our opinion, standardized data would point the audit teams toward potential areas of underuse which they could then review in more detail.

Enrollee grievances are another type of data which we believe could be used to direct audit teams toward potential problem areas. A report prepared by the Assistant Secretary of Research, California Health and Welfare Agency, stated that determining enrollee satisfaction does not, in itself, prove the quality of care provided by a PHP; but when enrollee criticism of the quality of medical services is at a minimum it does indicate that treatment of the welfare patient is acceptable or good.

In our opinion, the medical evaluation team normally did not follow DH regulations pertaining to reviewing grievances partly because management information, such as enrollee reasons for disenrollment and enrollee complaints on quality of medical services, were not evaluated by DH nor submitted to the evaluation team.

DH has not adequately evaluated and verified the reasons why patients have disenrolled from PHPs. Therefore, the data gathered often does not accurately convey existing or potential problems that DH should monitor and try to correct to improve PHP operations. Nevertheless, DH summations, which break down the reasons for disenrollment for all PHPs, showed that former enrollees were dissatisfied with the quality of health services. From March through October 1973, about 37 percent of former recipients disenrolled because they were (1) dissatisfied with the PHP services, (2) critical of the emergency services, (3) having long waits at the clinic, (4) lacking transportation to the clinics, or (5) having difficulty in getting appointments. Also, an additional 31 percent disenrolled because they preferred their own doctor. If DH had analyzed this latter category, additional quality-of-care deficiencies regarding physician services might have been identified.

Officials from DH's Medical Audits Section agreed that better grievance data would be useful in directing audit efforts to areas where deficiencies might exist. They stated, however, that quality of medical services, as viewed by patients, is not always indicative of the care provided by PHPs; and that, because most enrollee complaints lack validity, time spent reviewing other quality of care areas would be more productive than reviewing enrollee grievances. While we agree that a detailed review of enrollee grievances by the audit team at the PHP may not be the most productive use of the team's time, we believe that summarized data given to the team by DH before the audit would help direct their attention to potential problem areas.

## CONCLUSIONS

Enrollees have made many complaints about the quality of PHP medical care. Since generally accepted standards for assessing the

quality of medical care have not been developed by HEW or the State, DH relies on the judgment of physicians, who periodically review PHP operations.

Medical audit teams were spending relatively short periods of time (1/2 to 2 days) to evaluate PHP medical operations. Because of the amount of program activity at each PHP and the questions which have arisen about the quality of services provided, more detailed audits are probably warranted.

DH has not evaluated, or made available to audit teams, data it obtained from PHPs regarding patient visits, services provided, and number and length of hospital stays. DH should evaluate and make such data available to medical audit teams before their visits to PHPs. Also DH should make available to medical audit teams data regarding reasons for disenrollment and enrollee grievances.

Such data, as well as similar kinds of data, would help State audit teams identify potential weaknesses in PHP medical services. One of the reasons these types of data were not used was that the data as presently gathered is not standardized or accurate although DH is taking steps to standardize data. Standardized data could be used to direct audit team efforts toward problem areas.

HEW has not issued regulations prescribing the types of activities States should undertake to insure that HMOs provide quality medical services. Such regulations are necessary especially since more States will probably begin Medicaid HMO programs.

## RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator, SRS, to develop and promulgate regulations which would (1) identify items, such as reasons for disenrollment and use of services, which States can use to monitor PHP quality of care; (2) devise procedures to insure that accurate standardized data is available to medical audit teams; and (3) prescribe the types of actions States must take to insure HMOs provide quality medical services.

RUSSELL B. LONG, LA., CHAIRMAN  
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## United States Senate

COMMITTEE ON FINANCE  
 WASHINGTON, D.C. 20510

March 6, 1973

The Honorable  
 Elmer B. Staats  
 Comptroller General of the  
 United States  
 General Accounting Office  
 Washington, D. C. 20548

Dear Mr. Staats:

The Social Security Amendments of 1972, which are detailed and precise with respect to the Health Maintenance Organization concept (HMO) under Medicare, contain certain safeguards designed to prevent problems in the program. Similar safeguards were not included in the legislation for Medicaid primarily because of the variation in programs and benefits from State to State.

Allegations have been made regarding possible improprieties and inefficiencies in certain HMO operations under California's Medi-Cal (Medicaid) program. These allegations relate to (1) remuneration to persons as an inducement to secure enrollees in particular HMO's; (2) high turnover of enrolled recipients; and (3) lack of HMO capability to deliver services contracted for in a timely and complete fashion.

I would appreciate the General Accounting Office reviewing and evaluating the expanded HMO concept under the Medi-Cal program in California. Members of my staff discussed the particulars of this request with your representatives in several meetings this year. Specifically, I would like an evaluation of:

- the basis used in establishing payment rates for services provided,
- HMO enrollment procedures, including enrollment costs and a determination of whether fees are paid for enrollment,

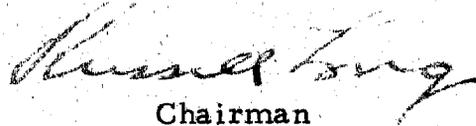
APPENDIX I

- HMO capability to deliver services, including scope and quality of services provided,
- arrangements made for delivering services (directly or by contract). If by contract, note any variations of contract terms (including subcontracts) from standard contract terms,
- the effectiveness of recipients' appeal rights,
- monthly turnover statistics of recipients, and
- potential or actual conflict-of-interest situations between HMO principals (anyone having a direct or indirect ownership of 5 percent or more) and sub-contractors and related organizations.

Your report on the results of the review would be appreciated as soon as possible. A copy of the report should also be made available to the Chairman, House Committee on Ways and Means.

I want to express again the Committee's appreciation for the valuable and extensive assistance provided by your office during the consideration of H. R. 1. The information was of great help in our consideration and development of reforms to the Medicare and Medicaid programs.

Sincerely,



Chairman

## APPENDIX II

### PHP CONTRACTS AND ENROLLMENT

PHP	Maximum allow- able enrollment	Enrollment as of October 31, 1973
Contra Costa County:		
Contra Costa	20,000	0
Kings County:		
Health Maintenance	3,600	0
Los Angeles County:		
Consolidated Medical Systems	100,000	44,369
Family Health Program	20,000	11,437
Central Los Angeles Health Project	20,000	9,161
Marvin Health Service, Inc.	30,000	12,636
DePaulo Medical Group	10,000	4,047
Gardena Medical Group	15,000	1,840
Harbor Health Services	12,000	7,397
Century City	5,000	0
Omni-Rx	12,000	4,688
Medbrook	15,000	4,795
Los Angeles Health Foundation	20,000	3,856
Century Health Plan	15,000	3,970
Westland Health Services	15,000	2,887
South Los Angeles Community Health Plan	15,000	4,565
Americare	10,000	2,960
Kaiser	8,000	952
Hawthorne Community Health Plan	15,000	1,963
Watts Multi-Purpose	16,000	2,327
Family Health Services, Inc.	16,000	1,348
Rose Medical Group, Inc.	10,000	533
Mission Hills Medical Group, Inc.	10,000	1,565
Newhall-Pacoima Medical Group, Inc.	10,000	1,160
UMEDCO Health Care Foundation	50,000	1,560
Ferrill J. Volpicelli, M.D., A Professional Corporation	10,000	0
Ventura Health Maintenance Medical Group (Los Angeles)	(a)	6
Security Health Plan	10,000	27
Bio-Med Health Service	10,000	0
Provident	10,000	0
Northeast Valley	6,000	0
Orange County:		
Security Health Plan	10,000	310
Family Health Program	10,000	4,401
Consolidated Medical Systems	10,000	4,600
Orange County Foundation	30,000	1,394
Health Care Association	8,000	610
Riverside County:		
Arlington University Medical Group, Inc.	15,000	2,761
Sacramento, Yolo, Placer, Nevada, and El Dorado Counties:		
Foundation Community Health Plan	56,000	36,593
San Bernardino County:		
Kaiser-Fontana	2,100	798
Consolidated Medical Systems	10,000	2,113
San Bernardino Family Medical Group	20,000	0
San Diego County:		
HCS	15,000	2,492
Consolidated Medical Systems	11,600	3,194
Davidson-Newton Medical Group, Inc.	20,000	72
Southern California Health Plan	15,000	832
Western Medical Group	25,000	2,364
Balboa-Genesee	10,000	200
San Francisco County:		
American Health Care Plan	40,000	2,654
Santa Clara County:		
Alviso Family Health Center	2,284	226
Tulare County:		
Health Maintenance	3,600	0
Ventura County:		
Ventura Health Maintenance Medical Group	6,000	649
San Mateo County:		
American Health Care Plan	(b)	0
Total	<u>838,184</u>	<u>196,312</u>
Total contracts	52	
Total plans	43	

<sup>a</sup>See Ventura Health Maintenance Medical Group, Ventura County.

<sup>b</sup>See American Health Care Plan, San Francisco County.

APPENDIX III

NUMBER OF ENROLLEES AND MEDICAID PAYMENTS  
TO PHPs INCLUDED IN REVIEW

	<u>Enrollment as of October 31, 1973</u>	<u>Medicaid payments for FY 1973</u>
Americare	2,960	\$ 244,368
Consolidated Medical Systems	44,369	12,124,085
Family Health Program	11,437	3,224,602
Omni-Rx	4,688	296,570
Sacramento Foundation Community Health Plan	36,593	8,076,988

PRINCIPAL HEW OFFICIALS  
RESPONSIBLE FOR ADMINISTERING  
ACTIVITIES DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
<b>SECRETARY OF HEALTH, EDUCATION, AND WELFARE:</b>		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
<b>ASSISTANT SECRETARY FOR HEALTH:</b>		
Dr. Charles C. Edwards	Apr. 1973	Present
<b>ADMINISTRATOR, SOCIAL AND REHABILITA- TION SERVICE:</b>		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
<b>COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:</b>		
Dr. Keith Weikel (acting)	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969