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MEDICARE MANAGED CARE

HMO Rates, Other Factors Create Uneven Availability of Benefits

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Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss aspects of Medicare managed care, including greater choice and equity across the program. In fiscal year 1997, federal expenditures for Medicare benefits are expected to reach nearly \$209 billion. The Congressional Budget Office estimates that costs will rise an average of 8.4 percent a year during fiscal years 1998 through 2002. As the Congress seeks ways to slow this growth rate, several proposals have been made that would encourage beneficiaries to join risk contract health maintenance organizations (HMO). Risk contract HMOs have the potential to be advantageous for two reasons. First, the payment of a capitated rate for all services needed by each enrolled beneficiary gives these plans a financial incentive to hold down costs.¹ In addition, risk contract HMOs often provide Medicare enrollees additional benefits at lower out-of-pocket costs than Medicare fee-for-service coverage.

As you know, Medicare risk HMO plans are not available nationwide, and differences in premiums charged and benefits offered across the country produce inequities for Medicare program beneficiaries. In addition, as we recently reported,² the risk contract program has not realized the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. Concerned about program inequities and the lack of savings from risk HMOs, you asked us to discuss the mechanics of the current risk HMO payment system and its shortcomings—including why the system produces differences in HMO availability and benefit packages for beneficiaries and fails to produce expected savings for taxpayers. I will focus on (1) the link between counties' capitation rates and Medicare's spending on fee-for-service care; (2) factors affecting the availability of plans in a given area, the level of premiums charged, and the benefit packages offered; and (3) modifications to Medicare's current payment methodology that could reduce HMO overpayments.

My remarks today are based primarily on analyses done for our recently issued work on HMO rate setting and the enrollment of HMOs in Medicare's risk contract program. (A list of related GAO products appears at the end of this statement.)

¹Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this statement.

²Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

In summary, Medicare's risk HMO payment system, which is built largely on fee-for-service costs, accounts for some, but not all, of the unevenness in Medicare's risk contract program. Differences in local medical prices and service utilization explain much of the variation in HMO capitation rates across counties. In turn, the variation in capitation rates explains some of the differences across locations in availability of risk contract HMOs, level of HMO premiums charged, and richness of benefits offered. However, other factors also play an important role.

Reducing the unevenness in, and realizing the savings potential of, the risk contract program involves reforming its payment system. As a start to that process, we have proposed correcting a flaw in Medicare's rate-setting method that currently contributes to excess payments to HMOs. Our proposed modification could also help smooth the unevenness in counties' HMO capitation rates.

Background

Medicare provides health care insurance for nearly all elderly Americans (those aged 65 and older) and certain of the nation's disabled. It is administered by the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services (HHS). Although most Medicare services are provided through the fee-for-service sector, in recent years, greater numbers of Medicare beneficiaries have enrolled in HMOs to receive covered services.

Medicare risk HMOs must cover all Medicare part A and part B services. However, many risk HMOs also cover part A and part B copayments and deductibles and additional services that are not covered under traditional Medicare—such as a portion of the costs of outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses. HMOs are allowed, subject to certain Medicare restrictions, to charge beneficiaries a monthly premium for cost-sharing and services not otherwise covered by Medicare. However, nearly two thirds of HMOs do not charge beneficiaries a monthly premium.³

Congressional interest in risk-bearing HMOs dates from the Social Security Act Amendments of 1972 (P.L. 92-603). Under the 1972 law, if an HMO's costs were less than its capitation payments, it was required to share these profits with Medicare. In addition, an HMO's profits were capped at 10 percent of its total payment from the government. However, if an HMO's costs exceeded its payments from Medicare, the HMO had to absorb the

³All beneficiaries enrolled in HMOs must, however, continue to pay their part B premium to Medicare.

loss or carry it over to offset future profits from its Medicare business. Few HMOs contracted with Medicare under this arrangement.

In 1982, the Congress modified Medicare's rate-setting method, creating the risk contract program that exists today.⁴ One significant change was that the Congress eliminated the 1972 law's requirement that an HMO's Medicare profits be completely shared with Medicare. Instead, HMOs are permitted to retain all profits up to the levels they earn on their non-Medicare business.

As of May 1, 1997, 280 HMOs⁵ participated in Medicare's risk contract program. Recent growth in enrollment of plans in the risk contract program has been rapid but uneven across the country. When we reported on 1994 enrollment trends, for example, 15 states had experienced double-digit growth increases, whereas the other states had experienced little or no growth.⁶ At the end of 1996, California, Florida, New York, Texas, and Washington had the largest number of risk contract HMOs, whereas 37 states had five or fewer of these plans. Medicare's enrollment of beneficiaries in risk HMOs is currently growing by about 85,000 beneficiaries per month. As of May 1, 1997, 4.6 million, or nearly 12 percent, of the approximately 39 million Medicare beneficiaries were enrolled in risk HMOs.

Diversity in Capitation Rates Across Counties Is Driven by Variation in Local Medicare Fee-for-Service Spending

Medicare law ties HMO capitation rates to spending in the traditional fee-for-service program. Every year, HCFA calculates per-beneficiary spending in each county's fee-for-service sector and, using projections of spending growth, determines capitation rates for each county in the following year. Fee-for-service costs vary widely among counties because of differences in medical prices paid and in beneficiaries' use of services. Therefore, HMO capitation rates, directly based on fee-for-service spending, can vary considerably from one county to another.

⁴The legislation creating this program is contained in section 114 of the Tax Equity and Fiscal Responsibility Act (P.L. 97-248).

⁵Competitive medical plans, which also enter into risk contracts with Medicare to serve beneficiaries, are included in this figure.

⁶Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

**HCFA's Process for
Determining an HMO's
Payment Rate Is Tied
Directly to Medicare's
Fee-for-Service Spending**

Medicare law stipulates that the capitation rate be set at 95 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service.⁷ Under Medicare's current rate-setting method, HCFA each year uses the Medicare costs incurred by a county's fee-for-service beneficiaries to develop an estimate of each county's average fee-for-service spending in the following year.⁸ The result, multiplied by 0.95, produces a county rate known as the adjusted average per capita cost (AAPCC).⁹ In projecting spending growth, HCFA's calculations take into account national trends in inflation and utilization patterns as well as changes in Medicare program provisions.

To arrive at the capitation rate paid for each HMO enrollee, HCFA applies a risk-adjustment factor to the AAPCC that is intended to align the rate with how much an enrollee's expected costs differ from the average beneficiary's cost. Our work has shown that, even after HCFA's risk adjustments, the capitation rate is only weakly related to a beneficiary's expected fee-for-service costs.

**Variation in Fee-for-Service
Spending Produces
Diversity in Counties'
AAPCC Rates**

In 1997, the average AAPCC was \$395 per month.¹⁰ However, AAPCC rates vary dramatically from place to place—from a low of \$221 in Arthur County, Nebraska, to \$767 in Richmond County (Staten Island), New York (see fig. 1). Even among counties in the same geographic area, substantial rate variation can exist. For example, in the Philadelphia metropolitan area, Philadelphia County's AAPCC is \$704, but in neighboring Montgomery County, Pennsylvania, the AAPCC is \$516. Because capitation rates are based on a beneficiary's county of residence, a Philadelphia-area HMO would receive \$188 more for serving a Philadelphia county resident than it would for serving a Montgomery County resident with identical demographic characteristics. The payment differential remains, even if the two beneficiaries see the same physician and use the same medical facilities.

⁷Section 1876(a)(4) of the Social Security Act (42 U.S.C 1395mm(a)(4) (1994)).

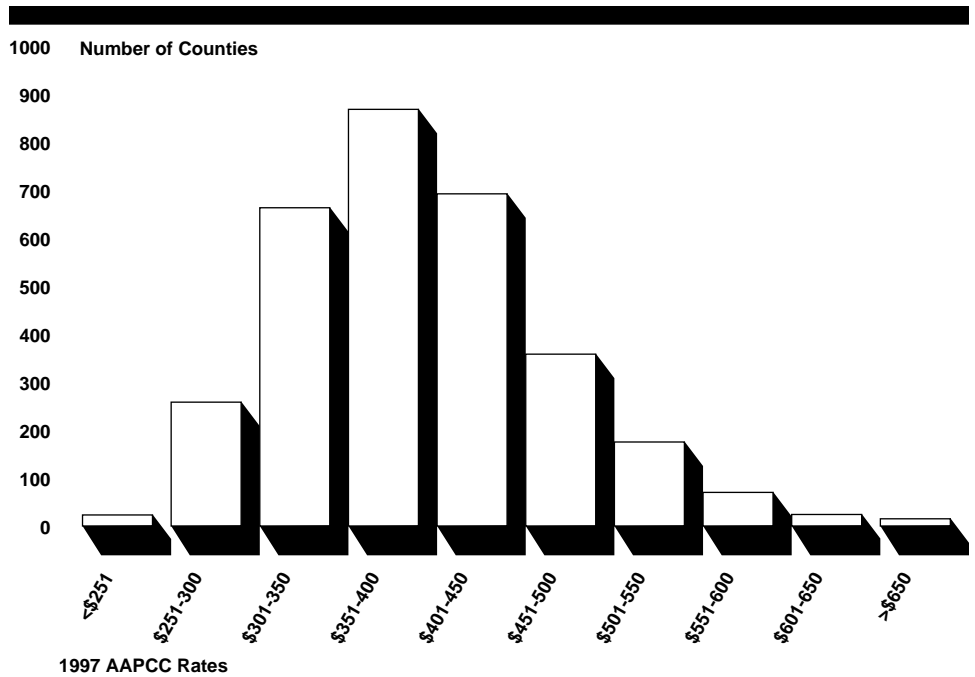
⁸Through this process, HCFA determines county-specific Medicare expenditures for part A and part B for the elderly and the disabled.

⁹HCFA calculates separate cost figures for Medicare part A and part B services for the aged, the disabled, and people with end-stage renal disease.

¹⁰The average county rate weighted by the number of beneficiaries living in each county is \$468. AAPCC rates discussed in this statement exclude rates for the U.S. territories.

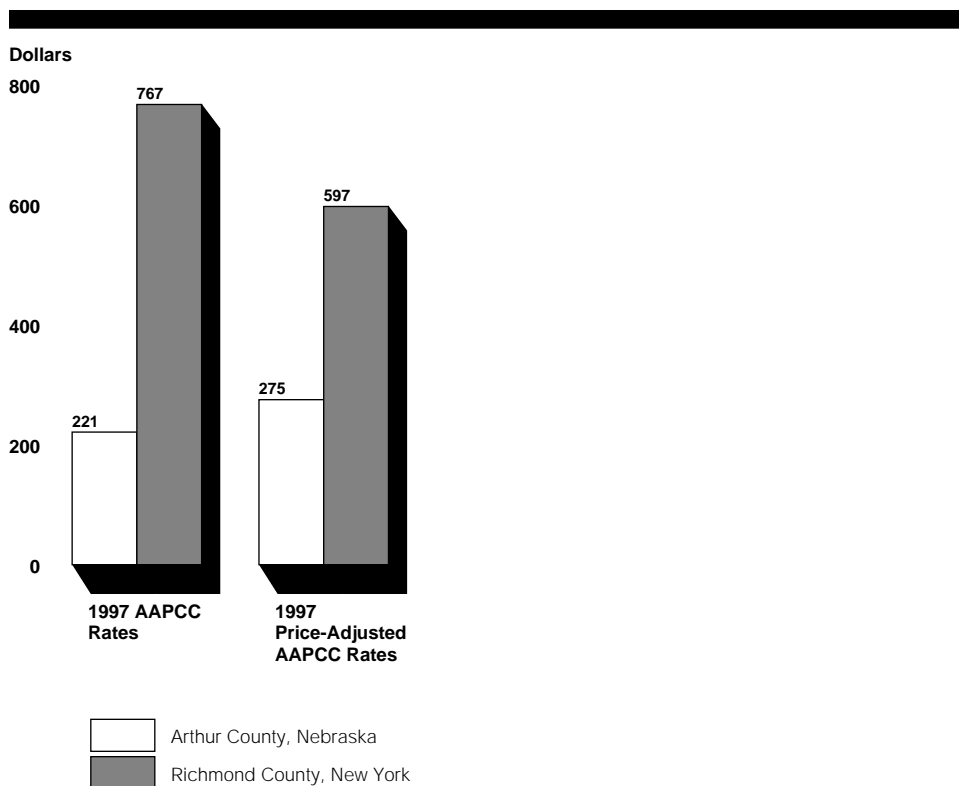
Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits

Figure 1: Distribution of Counties by 1997 AAPCC Rates



The wide variation in HMO payment rates is a consequence of the variation in local Medicare fee-for-service expenditures which, in turn, is caused by local differences in both the prices of medical services and the quantities of medical services consumed. To illustrate that price differences alone cannot fully explain the variation in AAPCC rates, figure 2 shows an estimate of the AAPCC rate that would exist in Arthur County, Nebraska, and Richmond County, New York, if the cost of medical services in both counties were equal to the national average. Although an adjustment for differences in medical prices reduces the original \$546 AAPCC rate differential by 39 percent, a gap of \$332 nevertheless remains.

Figure 2: 1997 AAPCC Rates and AAPCC Rates Adjusted for Local Medical Costs in Arthur County, Nebraska, and Richmond County, New York



Differences in the quantity of medical services beneficiaries receive account for the variation in AAPCC rates not attributable to differences in local prices. HMO capitation rates are higher in counties where beneficiaries use more services (or a more expensive mix of services) compared with counties where beneficiaries use fewer services. An example of variation in service utilization is Medicare beneficiaries' use of short-stay hospitals. In 1994, Utah beneficiaries averaged 1,270 days of hospital care per 1,000 beneficiaries, whereas New York beneficiaries averaged 3,738 days of hospital care per 1,000 beneficiaries.

Some of the variation in the use of medical services may reflect inappropriate levels of care. For example, low utilization could be caused by access-to-care barriers, such as inadequate transportation or a lack of providers in rural areas. Similarly, some high utilization could represent excessive use of medical services. Nonetheless, current fee-for-service

medical utilization rates—whether appropriate or not—are an important factor in determining HMO capitation payment rates.

HMO enrollment patterns may also contribute to the county variation in the use of fee-for-service medical services. It is widely acknowledged that HMO enrollees tend to be healthier than beneficiaries who remain in fee-for-service—a phenomenon known as favorable selection. As we recently reported, the growing enrollment of a county’s generally healthier Medicare beneficiaries in risk HMOs drives up the medical service use rates for the generally sicker beneficiaries remaining in fee-for-service.¹¹

Capitation Rates Alone Do Not Determine HMO Availability, Premiums Charged, or Benefits Offered

There is a significant correlation between Medicare’s capitation rates and the availability of Medicare HMOs in different areas, the premiums these plans charge, and the benefits they offer. However, a number of exceptions suggests that other factors, such as the concentration of Medicare beneficiaries and the availability of HMOs to the non-Medicare population, play an important role.

Population Size and Rate Volatility Also Likely Influence Plan Participation in a Given Area

Medicare HMOs are not available everywhere. Nationally, 63 percent of beneficiaries have at least one plan available to them; 25 percent have five or more plans available. Many HMOs are concentrated in urban areas, while rural areas have few or no HMOs. Because capitation rates are typically higher in urban areas than in rural areas, Medicare payment rates to HMOs are often considered to be an important influence on Medicare HMO availability. However, other factors—such as county size and the stability of the capitation rate from year to year—also play a key role.

Many counties with low AAPCCS are sparsely populated. Such counties simply may not have enough potential enrollees to make an HMO financially viable. As we recently reported, HMO officials have stated that plans need to enroll at least 10,000 Medicare beneficiaries within a few years to spread both financial risk and their fixed costs.¹² In addition, many rural counties are not served by commercial HMOs. This precludes the formation of Medicare HMOs, because Medicare requires that HMOs serving rural areas

¹¹GAO/HEHS-97-16, Apr. 25, 1997.

¹²Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

have at least 1,500 commercial members (5,000 for nonrural HMOs) and that at least 50 percent of their enrollees be commercial members.

Instability of capitation rates from year to year may also discourage some HMOs from locating in areas with few beneficiaries. Between 1996 and 1997, the average AAPCC rate increased by about \$23, or just over 6 percent. However, some counties' rates increased much more than the average while others decreased substantially.¹³ In counties with a small number of beneficiaries, a relatively few expensive medical cases in 1 year can drive up Medicare fee-for-service expenditures (and therefore HMO rates), while an especially "healthy" year can reduce expenditures. HMO officials have stated that such rate instability impairs long-term planning efforts—for example, by complicating decisions about investing in new clinics and expanding physician networks. By using a 5-year average of fee-for-service data to determine a county's AAPCC rate, HCFA dampens—but does not eliminate—the effect of fluctuating fee-for-service costs on HMO payment rates.

HMO Profit Restrictions, Competition Also Influence Premium Rates and Benefit Packages

Beneficiaries' out-of-pocket costs and the benefits they receive depend on where they live as well as on which HMO they join. For example, beneficiaries living in southern California who enroll in PacifiCare pay no monthly premium and may receive an unlimited annual prescription drug benefit. In contrast, beneficiaries who enroll in PacifiCare in Portland, Oregon, pay a \$37 monthly premium and receive no prescription drug benefit.

Geographic differences in capitation rates (PacifiCare of southern California receives an average monthly capitation rate of \$497, while PacifiCare of Oregon receives \$338) explain part of the premium and benefit variation, but not all. Restrictions on HMO profits and the amount of local competition among HMOs also influence the out-of-pocket costs beneficiaries must pay and the benefits they receive.

Medicare's HMO Profit Restrictions

Medicare's restrictions on HMOs' profit-making partly explain the link between capitation payments to HMOs and their benefit packages. Medicare does not permit HMOs to earn profits on their risk contracts that are higher than on their commercial business. If HCFA estimates that the capitation payments would result in an HMO earning excess profits, the plan must reduce premiums (or other beneficiary out-of-pocket expenses), offer

¹³For example, the AAPCC rate in Loving County, Texas, fell 40 percent (from \$881 to \$527), while the rate in Culberson County, Texas, rose 37 percent (\$355 to \$487).

additional benefits, or return money to the program. Virtually all HMOs in this situation decide to reduce premiums or offer additional benefits.

HCFA attempts to enforce Medicare's restrictions on HMOs' profits through what is known as the "adjusted community rate" (ACR) process. Before each contract year, every HMO submits to HCFA a proposal—called the ACR proposal—that describes the HMO's planned package of benefits (which may go beyond those covered by fee-for-service Medicare) and monthly premiums and other charges to beneficiaries. The ACR also includes an estimate of the amount the HMO would have charged commercial enrollees for a similar benefit package. Although this estimate may initially be based on HMOs' actual charges, numerous adjustments must be made to account for the generally higher utilization of services by Medicare beneficiaries compared with commercial enrollees and any differences in benefit coverage between the two groups. HCFA reviews the ACR proposal to determine whether the plan must offer additional benefits to enrollees and the maximum premium the plan will be permitted to charge. The net result is that the more an HMO will profit from its Medicare business, the more additional benefits Medicare enrollees receive.

Competition for Market Share

The amount of local competition among HMOs for market share can also influence the level of HMO premiums and benefits. Through the ACR process, HCFA approves the maximum premium (and other beneficiary out-of-pocket costs) an HMO may charge for its proposed benefit package. HMOs may, however, charge a premium lower than the one approved by HCFA or offer benefits beyond those included in the plan's ACR proposal. Many HMOs seeking greater market share take advantage of this option. For example, Health Options, Inc., operating in the competitive south Florida market, is permitted to charge a monthly premium of \$94 for the package of benefits contained in its ACR proposal. However, Health Options has waived this premium—beneficiaries pay no monthly fee. PacifiCare, in the competitive Los Angeles market, is allowed to charge a \$12 monthly premium for its package of benefits, which includes a prescription drug benefit with a \$2,500 annual limit. As with Health Options, however, market forces induced PacifiCare to go beyond the ACR requirements. PacifiCare enrollees in the Los Angeles area pay no monthly premium, and some receive an unlimited annual drug benefit.

Correcting Rate-Setting Flaws Addresses HMO Overpayment Problem, May Reduce Risk Contract Program Unevenness

The variation in the risk contract program that produces inequities across the country in Medicare beneficiaries' costs and benefits is a manifestation of rate-setting flaws that produce HMO overpayments. As mentioned earlier, favorable selection—the tendency of HMOs to attract healthier than average beneficiaries—produces AAPCC rates that are higher than warranted in some counties. Favorable selection can result in overpayments to HMOs in two ways.

First, as discussed earlier, estimating a county's average cost of serving Medicare beneficiaries under fee-for-service is central to the current method for setting HMO rates. The problem is that HCFA's method excludes HMO enrollees' costs from estimates of the per-beneficiary average cost and bases the AAPCC only on the cost of the county's fee-for-service beneficiaries. Thus, the rates generated reflect the costs of only a portion of the county's Medicare beneficiaries—a portion which, according to the preponderance of research on this subject, is generally more costly than the portion of beneficiaries enrolled in HMOs. In this way, the current method generates rates that result in overpayments to HMOs in counties where the Medicare HMO population is, on average, healthier than the Medicare fee-for-service population.

A difficulty in correcting the problem is that HCFA cannot directly observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. We have proposed a modification that addresses this problem. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA, thus generating an AAPCC that represents the costs of all Medicare beneficiaries in the county.

On the basis of our work examining the AAPCC rates of California's 58 counties,¹⁴ we found that in 1995 our method would have reduced excess payments to HMOs by \$276 million, or about 25 percent of total excess payments. Thus, if HCFA adopted our modification, Medicare could save hundreds of millions of dollars in HMO overpayments.

HCFA recognizes the effect of favorable selection on AAPCC rates. The administration's current budget proposal calls for an across-the-board reduction in Medicare's HMO payments that would lower the payments from 95 percent to 90 percent of estimated fee-for-service costs. Our

¹⁴We selected California because, at the time of our review, it covered 36 percent of all Medicare enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. Our estimates pertain to a large portion of the risk contract program; we did not develop a national estimate.

modification to calculating AAPCC rates takes a more targeted approach. Under our method, HMOs in counties with higher excess payments would receive greater payment reductions than HMOs in counties with lower excess payments. The modification could be applied to HCFA's current payment method or other methods that rely on fee-for-service costs to set or update HMO rates. (See the appendix for a more detailed discussion of our work.)

Second, favorable selection results in overpayments to HMOs because of HCFA's method of risk adjustment. Medicare's risk adjusters explain only about 3 percent of the variation in individual-level health care costs and are thus not adequate to account for the cost differences among beneficiaries. The difficulty is that the risk adjusters are not precise enough to distinguish between two beneficiaries who may be demographically identical but who may have significant health differences. For example, of two beneficiaries alike in age, sex, and the other demographic traits considered by HCFA's risk adjusters, one may experience occasional minor ailments, while the other may suffer from a serious chronic condition. Because such dramatic differences in health status are not captured in risk adjustment, some HMOs receive payments that are higher than justified by the expected costs of their enrollees.

HCFA announced in January 1997 that it was about to launch a demonstration project on two risk-adjustment systems that seek to differentiate more and less costly patients on the basis of diagnostic information from inpatient, outpatient, and physician encounters. HCFA has not announced a schedule for implementing a better risk adjuster programwide.

Conclusions

The AAPCC system, with its linkage to fee-for-service expenditures, is an imperfect mechanism for setting capitation rates. It incorporates some local factors—such as service utilization differences—that may be inappropriate without adequate adjustments. As a result, the system assigns some counties AAPCC rates that are too low and other counties rates that are too high. Coupled with such factors as market competition and Medicare's complex ACR process, Medicare's payment system results in dramatic contrasts in HMO plan availability, out-of-pocket beneficiary costs, and benefit packages. Addressing the flaws in setting capitation rates is essential if the risk contract program is to realize the potential of program savings, enhanced benefits, and beneficiary equity.

**Medicare Managed Care: HMO Rates, Other
Factors Create Uneven Availability of
Benefits**

Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions.

Contributors

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Including HMO Enrollees' Costs in County Average Calculation Improves Accuracy of AAPCC

Modifying the method for calculating adjusted average per capita cost (AAPCC) rates would help reduce Medicare's excess health maintenance organization (HMO) payments in counties with healthier-than-average Medicare HMO enrollees. In setting AAPCC rates, the Health Care Financing Administration (HCFA) currently estimates the average Medicare costs of a county's beneficiaries using the costs of only those beneficiaries in Medicare's fee-for-service sector. This method would be appropriate if the average health cost of fee-for-service beneficiaries were the same as that of demographically comparable HMO enrollees. However, in counties where there are cost differences between Medicare's fee-for-service and HMO enrollee populations, this method can either overstate the average costs of Medicare beneficiaries and lead to overpayment or understate average costs and lead to underpayment. Correcting this problem is difficult because it is impossible to observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Therefore, we developed a method to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our method consists of two main steps:

- First, we compute the average cost of demographically similar new HMO enrollees during the year before they enrolled—that is, while they were still in fee-for-service Medicare. These fee-for-service costs are available through HCFA's claims data.
- Next, we adjust this amount to reflect the expectation that a new enrollee's use of health services will, over time, rise.¹⁵

Having completed these steps, we combine the result with an estimate of the average cost of fee-for-service beneficiaries. This new average produces an AAPCC rate that reflects the costs of all Medicare beneficiaries.

Selected 1995 AAPCC Rates Produced Substantial Excess Payments

To illustrate the effect of our approach, we analyzed data for counties with different shares of beneficiaries enrolled in HMOs. We chose counties within a single state to eliminate variations attributable to state differences. We selected California because, at the time of our review, it covered 36 percent of all Medicare HMO enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. We found that our method could have reduced excess payments by more than 25 percent.

¹⁵Our analysis adjusts for (1) the tendency for enrollees' costs to become more like—or “regress” toward—the fee-for-service cost mean after joining an HMO and (2) the costs incurred by HMO enrollees who die while enrolled, because last-year-of-life costs are typically high relative to those incurred in preceding years. How our method accounts for these costs is discussed more thoroughly in GAO/HEHS-97-16.

Although better risk adjusters could further reduce the large remainder of excess payments, improving risk adjustment is a complex effort that may take years to implement full-scale.

The following key points also emerged from our analysis:

- First, for the counties that we analyzed, we estimated that total excess payments in 1995 amounted to about \$1 billion (of about \$6 billion in total Medicare payments to risk HMOs in the state). Applying our method for setting AAPCC rates would have reduced the \$1 billion in excess payments by about \$276 million.
- Second, the excess payments attributable to inflated AAPCC rates were concentrated in 12 counties with large HMO enrollment and ranged from less than 1 percent to 6.6 percent of the counties' total HMO payments, representing between \$200,000 and \$135.3 million.¹⁶ Despite the size of these amounts, the application of our method would have produced relatively small changes in the monthly, per-beneficiary capitation payments, ranging from \$3 to \$38.
- Third, our analysis did not support the hypothesis, put forward by the HMO industry and others, that the excess payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs progressively enroll a more expensive mix of beneficiaries. Our analysis—which includes data from counties with up to a 39-percent HMO penetration in 1995—indicated that the difference between Medicare rates and our rates is larger in counties with higher Medicare penetration. For example, the four counties with the highest rates of excess payment, ranging from 5.1 to 6.6 percent, were also among the counties with the highest HMO enrollment percentages in 1995.

Data Are Available to Enable HCFA to Promptly Adjust AAPCC Rates

Because the data we used to estimate HMO enrollees' costs come from data that HCFA compiles to update HMO rates each year, our method has two important advantages. First, HCFA's implementation of our proposal could be achieved in a relatively short time. The time element is important, because the prompt implementation of our method would avoid locking the current methodological flaw into any adopted changes to Medicare's HMO payment method that continued to use current AAPCC rates as a baseline or fee-for-service costs to set future rates. Second, the availability of the data would also make our proposal economical: the savings to be

¹⁶For the state's remaining 46 counties, excess payments attributable to inflated county rates amounted to less than 3 percent of the 58-county total.

**Appendix I
Including HMO Enrollees' Costs in County
Average Calculation Improves Accuracy of
AAPCC**

achieved from reducing AAPCC excess payments would be much greater than the administrative costs of implementing the process.

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Related GAO Products

Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates (GAO/T-HEHS-97-78, Feb. 25, 1997).

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

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