Medicare HMO Ambulatory Service Denials: Determinants and Consequences

Ariel Linden, Dr.P.H., M.S., Stuart O. Schweitzer, Ph.D.

Presented by: Ariel Linden, Dr.P.H., M.S., Department of Health Services, School of Public Health, University of California, Los Angeles, CA 90095-1772, Tel: 310-825-2595; Fax: 310-825-3317; e-mail: ariellinden@yahoo.com

Research Objective: Advocates of HMOs contend that prospective payment creates a financial incentive for prevention and early detection of disease, thus avoiding the larger costs of treatment and, especially, hospitalization. Critics of this concept, on the other hand, argue that HMOs merely create incentives to deny needed services by paying providers through capitation. This paper examines whether reimbursement methods employed in an HMO influenced the rate of service denials to Medicare members, and if those denials subsequently affected membership retention.

Study Design: All data used in this study was provided by a medium-sized network model HMO in Southern California which served approximately 45,000 Medicare beneficiaries in 1997. We implemented a retrospective cross-sectional design in which 78 physician groups contracting with the HMO were utilized as the unit of measure. In the first analysis, a multivariate regression equation was estimated to determine the relationship between the dependent variable, "total ambulatory service denials/1000 members" for each physician group, and several explanatory variables including: method of physician group reimbursement (capitation/shared risk, or per-diem payment), demographic characteristics of each group's membership, and their hospital utilization rates. Ambulatory service denials covered a 12 month period beginning in January, 1997. In the second analysis, using a univariate model, we tested the hypothesis that higher physician group denial rates (explanatory variable) would lead to higher disenrollment rates of their Medicare members (dependent variable). Both variables were 6 month aggregates for each medical group, with the independent variable lagged 6 months behind the dependent variable. Denials covered the first half of FY 1997, while disenrollment pertained to the second half of the fiscal year.

Population Studied: 78 physician groups contracting with a medium-sized California HMO.

Principal Findings: Compared with physician groups reimbursed at a per-diem rate (N=38), those groups paid either by capitation or a shared risk agreement (N=40) were significantly more likely to deny ambulatory services to their Medicare members. Hospital utilization and age of the physician group's Medicare recipients were also significantly associated with denial rates, suggesting that control variables related to increased contact with providers may indicate an increased exposure to risk of being denied ambulatory services. The results of the

secondary analysis indicated that service denials occurring within the first half of 1996 were significantly associated with subsequent disenrollment occurring in the latter half of 1996.

Conclusions: These findings suggest that capitated payment arrangements between the HMO and provider groups lead to higher rates of ambulatory service denials in the Medicare population and that those denials may ultimately lead to member dissatisfaction and their subsequent disenrollment from the health plan.

Implications for Policy, Delivery or Practice: According to existing Medicare policy, beneficiaries are entitled to switch health plans at will. Therefore, recipients who enroll without understanding the implications of HMO service delivery and those who are dissatisfied with the quality of services they receive are apt to disenroll more readily. Recent Medicare legislation in the Balanced Budget Act of 1997 will systematically limit the number of times per year that a Medicare recipient may switch between health plans. While this may help to reduce the overall burden on the health care system, it may prove detrimental to the health status of Medicare recipients currently enrolled in HMOs who contract with providers on a capitated basis.

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