Why Some HMOs Develop Slowly

GEORGE B. STRUMPF, MPA, and MARIE A. GARRAMONE

Reasons for the termination of 37 projects funded before and 29 projects funded after the signing of the HMO Act are examined and compared with the findings of earlier studies of the viability of comprehensive prepayment plans.

BEFORE THE HEALTH MAINTENANCE ORGANIZATION Act was signed in 1973, an experimental program was undertaken to determine how effectively health maintenance organizations (HMOs) could be established in a variety of operational formats and environmental settings. These experiments in the Health Services and Mental Health Administration (HSMHA) began in early 1971 and continued until late in 1973. Grant funds were awarded to 79 organizations to develop HMOs during this experimental period. In 37 instances the decision was reached—usually jointly by the sponsor and HSMHA—that HMO activity would not be feasible in these particular settings.

We have sought to identify the major reasons why these 37 organizations did not progress beyond early development. We have also identified the major reasons why 29 of the 108 feasibility projects funded in fiscal year 1975 under the HMO Act (Public Law 93-222) did not progress to more advanced stages. We compared our findings with earlier studies that identified requirements for developing comprehensive direct service prepayment programs, focused on the barriers to initiation of prepaid group practice plans, and dealt with reasons for the failures of group medical practices.

This study is part of an ongoing activity of the Division of Health Maintenance Organizations (DHMO) of the Health Services Administration and is responsive to the requirement in the HMO Act for an annual report to the Congress (*1a*) summarizing specific program activities. The Division is also interested in identifying the requisite conditions and circumstances that will enable the maximum number of projects to eventually become qualified HMOs.

Pre-Act Grantees

During the pre-act period, 79 organizations received $16.5 million in grant funds. Of the 79 organizations, 37 have terminated HMO development, 17 became operational prepaid health plans without requesting funding under the HMO Act, and 25 have received additional developmental funding under the act (table 1). Eighteen of these 25 also are operational prepaid health plans. Therefore, a total of 35 organizations funded before the act became operational and are serving more than 321,000 enrollees. Of these, seven are qualified HMOs. To date, there are 21 qualified HMOs, and 39 percent of them received pre-act funds.

The HMO Program staff forecast in November 1973 (*2*) that of the 79 agencies receiving grants in the pre-act period, 42 organizations would become operational by 1975. Seven of the 25 that have received pre-act and post-act funds are still active. When they achieve operational status, the earlier projection of 42 operational HMOs by 1975 will be realized, albeit a year later than forecasted.

☐ *Mr. Strumpf is deputy director, and Ms. Garramone is a program analyst in the Monitoring and Reporting Branch of the Division of Health Maintenance Organizations, Health Services Administration, Public Health Service. Tearsheet requests to Marketing Branch, Division of Health Maintenance Organizations, 12A-08 Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.*

The 37 organizations that terminated HMO activity were analyzed by Regional and Central Office HMO staff to identify the principal reasons for their termination. This review by the HMO staff was conducted in early 1974, when regulations to implement the act were being formulated. The analysis significantly influenced the regulations, resulting in highly specific requirements for activities to be carried out during each of the three stages of grant activity (*3a*) and in explicit review criteria (*3b*) to be applied to grant applications at each stage.

The individual practice associations, characterized by physician-sponsored, open-panel type HMOs, had the lowest termination rate (32 percent). The highest percentage of terminations (63 percent) occurred among hospital-sponsored projects. Terminations were essentially the same (50 percent) among medical group practices and community-sponsored organizations.

The reasons for termination are presented in table 2. The most frequent cause was considered to be insufficient commitment of the sponsors, followed by lack of management capability and commitment of the project staff. The community-sponsored organizations seemed to have experienced more difficulty than any other type; 50 percent had strong opposition from organized medicine, 75 percent were judged to have had insufficient sponsor commitment, 50 percent demonstrated lack of management capability and commitment, and 17 percent were judged to give other activities a higher priority than HMO development. All of the medical schools and hospital-sponsored plans were considered to be insufficiently committed to HMO

Table 1. Status of 79 projects funded before passage of the HMO Act

Status	Number of grantees	Sponsorship					Geographic location	
		Medical group practices	Individual practice associations	Community organizations	Hospitals	Medical schools	Metropolitan	Nonmetropolitan
Expired	37	9	6	12	7	3	22	15
Received further funding under the act	25	5	8	8	1	3	19	6
Received no additional funds under the act	17	5	5	4	3	0	13	4
Total	79	19	19	24	11	6	54	25

development, as were 83 percent of the individual practice associations. A clear statement of recognition of the need to examine the hospital's commitment before planning the development of an HMO was given in a 1974 American Hospital Association publication (*4*).

The term "insufficient commitment" was used to describe circumstances in which there was not complete involvement or engagement of the sponsoring organization in the goal of achieving an operational HMO. The concept of commitment had two components—adequacy and appropriateness. The experience of the preceding 40 years in developing HMO-like organizations indicates that this has never been easy, and commitment equal to the task is essential for a successful outcome. Also essential is a commitment to the objectives of the sponsoring organization, and they must be objectives that the HMO is capable of accomplishing. It was not unusual to find that the projected HMO was expected to solve such problems as inadequate income to purchase comprehensive health care, a virtual lack of primary care physicians in the area, or low occupancy rates for a hospital. Although these problems were important to the sponsor, formation of an HMO was not an appropriate approach to solving them.

The phrase "lack of management capability and commitment" described circumstances in which it was apparent that persons with the many, varied skills essential to developing an HMO were not on the sponsors' staff or could not be hired. A major indicator of this circumstance was the extensive use of consultants to perform continuing tasks, such as marketing, financial planning, or development of a management plan, which project staff should be expected to perform. Another significant indicator was the lack of internal consistency between enrollment forecasts and financial plans, a deficiency that resulted in conflicting assumptions, cash flow analyses not supported by detailed justifications, and generally overoptimistic membership forecasts.

Post-Act Grantees

During fiscal year 1975, feasibility grants were awarded to 108 organizations. Because many grants were awarded late in the fiscal year, final results are not available from most of the 108 organizations. Currently 41 grants have expired, 35 projects are still active in the feasibility stage, and 32 have received funding for planning or initial development (table 3). Of the 41 expired grants, information was available concerning the causes of termination of 29. This information was analyzed by Regional and Central Office HMO staff and the reasons for termination were identified (table 4).

Although the commitment of the sponsoring organization was a major reason for termination (as demonstrated by pre-act grantees), two new reasons for termination have appeared: an apparent lack of understanding by grantees of the goals and objectives of the act

Table 2. Frequency of reasons why 37 pre-act grantees terminated HMO activity, by sponsorship

Reason	*Hospitals (N = 7)*	*Community organizations (N = 12)*	*Medical group practices (N = 9)*	*Medical schools (N = 3)*	*Individual practice associations (N = 6)*
Strong physician opposition	0	6	2	0	1
Insufficient commitment	7	9	6	3	5
Lack of management capability and commitment	2	6	5	1	3
Other priorities	3	2	3	1	2

Table 3. Current status of feasibility grants given 108 organizations in fiscal year 1975

Status	*Number of grantees*	*Sponsorship*					
		Public organizations	*Consumer groups*	*Medical schools*	*Hospitals*	*Physician groups*	*Private organizations*
Expired	41	0	14	0	14	11	2
Funded for planning	32	0	16	1	4	8	3
In feasibility stage	35	4	17	1	3	9	1
Total	108	4	47	2	21	28	6

Table 4. Frequency of reasons why 29 projects given feasibility grants did not proceed under the HMO Act

Reason	Sponsorship				
	Consumer groups (N = 9)	Hospitals (N = 10)	Physician groups (N = 9)	Private organizations (N = 1)	Total reasons
Insufficient sponsor commitment	4	6	5	0	15
Lack of understanding of goals and objectives of HMO Act	8	8	8	1	25
Provider opposition	1	1	2	0	4
Lack of providers	5	5	7	1	18
Failed to supply marketing or financial feasibility outputs	8	9	9	1	27

and the failure to supply the feasibility outputs required by the regulations and guidelines (*5*).

Lack of understanding was apparent if the grantee proposed a plan at the end of the feasibility stage that was unquestionably inconsistent with the requirements of the act.

In 27 of the 29 projects, failure to comply with the requirements to demonstrate feasibility occurred as frequently as lack of understanding of the sponsoring organizations. The requirements are explicit and include recommended formats for displaying the feasibility information (*6*). Failure to supply this information was therefore considered to represent the organization's inability to apply grant funds in an orderly manner to accomplish the specified tasks.

Lack of providers was a reason for termination in 62 percent of the projects. The act mandates a comprehensive set of basic health services that must be provided without limitation as to time or cost. Problems resulting from the statutory requirement for this broad range of services have been discussed in recent testimony in both the House of Representatives and the Senate (*7, 8*). The basic health services and the particular manner in which they must be provided (*1b*) apparently resulted in many sponsors being unable either to find physicians and hospitals who would be available to the HMO or to establish arrangements with physicians that would comply with the narrow requirements of the act.

Comparing Reasons for Termination

Comparing the reasons for termination of 29 post-act projects to the outcomes of the projects funded in the pre-act period leads to some preliminary conclusions.

First, in both groups of projects the nature and depth of commitment by the sponsoring organization was a major reason for termination. Lack of understanding of the purposes of the act is believed to represent the same problems that were characterized in the 1974 analysis as insufficient or inappropriate commitment (*3c*).

Second, inadequate management also appears to have been a major reason for termination in both periods. The failure of 27 of the 29 terminated projects to supply the specified, required documentation of feasibility can be attributed to lack of management capability. In using the phrase "failed to supply feasibility outputs" (table 4), we emphasized behavioral aspects, while in the 1974 study the term "lack of management capability and commitment" (table 2) emphasized the reasons underlying the behavior of the project staff. We believe that the nature and quality of the top managerial staff of the projects was a major factor in the termination of HMO activity for both sets of grantees.

Finally, lack of health care providers available to the post-act projects is believed to be directly attributable to the formidable barriers the act presented to multispeciality group practices and foundations for medical care—barriers that discouraged their participation in HMOs. A 1974 DHMO staff comparison of the percentage of grant applications sponsored by physician-controlled organizations (that is, group practices and foundations) before and after the act showed a substantial decline in applications from these groups. This decline is attributed to restrictive features in the act such as the principal professional activity requirement (*1c*) and the requirement that there be an HMO in addition to a separate entity, that is, the individual practice association (*1d*).

Related Studies

A significant amount of information is available on requirements for development of comprehensive, direct-service prepayment plans (*9–17*), barriers to initiation of prepaid group practice plans (*18–20*), and reasons for the failure of medical group practices (*21, 22*). Each of these three groups of studies has been summarized to compare earlier work with our findings.

Many researchers agreed on the essential requirements for the development of comprehensive plans (table 5). Among the objective conditions nearly always mentioned were an adequate population base, a

Table 5. Requirements for development of a comprehensive prepayment plan cited in nine studies

Authors	*Objective conditions*	*Medical care conditions*	*Financial needs*	*Subjective conditions*
Bush, reference *9*	• Favorable legal climate • Adequate population base	• Strong medical leadership • Attractive environment for health professionals	• Adequate financing	• A felt need in the community • Chance for broad community participation
Donabedian, reference *10*		• Physician commitment • Organization, recruitment and standards of medical staff • Effectiveness of medical care		• Public acceptance • Subscriber satisfaction
MacColl, reference *11*	• Adequate population base • Legally practical	• Professionally attractive		• Felt need for a program • Devoted person or group • Broad community orientation • Reasonable chance of success in sight
McKay, reference *12*	• Broadly based membership • Facility locations • Use of community hospitals	• Adequate rates		• Committed individuals • Community responsiveness • Voluntary enrollment
Pollack, reference *13*		• Doctors	• Financing and financial planning	• Leadership • Management • Policy set by community leaders
Saward, reference *14*	• Adequate critical population mass	• Adequately staffed medical group	• Money	• Sound management • Sufficient motivation • Membership orientation
Vayda, reference *15*	• Nonprofit structure • Broadly based membership	• Medical group autonomy • Hospital based	• Financially self sustaining • Comprehensive benefits with adequate premiums	• Voluntary enrollment in dual situation
Vohs, reference *16*	• Sufficient population • Sound local economy • Legal environment • Ownership and operation of a hospital • Competition in area	• Physician nucleus	• Capital availability	• Skilled personnel • Firm commitment of plan leaders • Community impact
Yedidia, reference *17*	• Facilities	• Qualified medical staff suited to this type of practice • Personnel	• Capital for all phases	• Consumers who want prepaid comprehensive medical care • Services that meet consumer needs, within provider capacities

positive legal environment, and a nucleus of physicians with a strong interest in serving members of a prepaid comprehensive plan. Sufficient capital for planning and early operational deficits was listed early in almost every enumeration.

Many requirements were subjective, and most researchers listed more of these than other kinds. Management, motivation, and felt needs in the community appeared frequently. The emphasis on such requirements is consistent with our findings identifying similar subjective conditions as the leading causes of termination. The significance of these subjective requirements is that they raise the question of whether it is possible to determine the likelihood of an HMO's success before substantial time and money have been expended in exploring objective issues such as capital requirements, legal climate, and provider availability and in exploring the nature and depth of the capabilities and commitments of key groups and persons.

A few investigators have also analyzed the barriers to success of prepaid group practice plans (table 6). Although they substantially agree with other observers on the financial, legal, and managerial problems, new issues were raised by Du Val and Yedidia (*19, 20*). Because their work was the most recent of the sources cited (1972 and 1973) and they had had the opportunity to observe the early implementation of federally supported HMO activity, they were able to call attention to the imposition by multiple governmental and nongovernmental bodies of complex legal and technical requirements. The problem becomes manifest if one examines the varying definitions of an HMO in three Federal laws—the Amendments to the Social Security Act (Public Law 92-603), the Health Maintenance Organization Act of 1973 (Public Law 93-222), and the Health Planning and Resources Development Act of 1974 (Public Law 93-641)—as well as the regulations issued through the Social Security Administration, the Social and Rehabilitation Service, the Health Services Administration, and the Civil Service Commission.

Authors of studies of unsuccessful medical group practices concluded that failure to observe basic principles of organization and management was the cause for discontinuance. Lack of agreement on goals (for example, clearly formulated purposes were not consciously shared) resulted in a lack of cooperation and discontinuance of group activity. Dubois (*22*) concluded that failure "can result from organizational objectives which lead to organizational policies in conflict with the professional role or from failure to define or support organizational objectives as a central theme around which the organization is operated." Other factors associated with failure were hostile professional environments and poor administrative management. Conversely, high group viability was "associated with organizational objectives based upon, or supportive of performance of the professional role."

Table 6. Barriers to initiation of prepaid group practice plans cited in three studies

Authors	*Legal or regulatory*	*Medical care*	*Financial*	*Managerial*
DuVal, reference *19*	• Legal barriers • Uncoordinated Federal activity		• Total financial requirements for all stages	• Lack of management and technical expertise • Lack of public and provider awareness of advantages and disadvantages
Greenburg and Rodburg, reference *18*	• Legal barriers • Prohibitive legislation • Burdensome insurance regulations	• Professional opposition	• Outside source of funds • Sufficient size for economic survival	• Insufficient managerial expertise
Yedidia, reference *20*	• Complex legal and technical requirements of governmental bodies • Health industry is dominated by a fee-for-service orientation	• Problems with resolving the distribution of income by the medical group • Reimbursement problems caused by time needed to purchase specialty services	• Funds to access large population groups	

Discussion

The reasons for termination of HMO development activity in the two groups (37 pre-act and 29 post-act projects) have been compared. The causes were also compared with the reasons cited in earlier studies. Management, motivation, and physician involvement were major elements in the failure or success of HMOs.

Insufficient management expertise was a major reason for ending the post-act projects, was the second most frequent reason for failure of the pre-act projects, and was specifically cited by authors of 8 of the 13 earlier studies as critical to the development of an HMO-like plan. Insufficient sponsor commitment was the leading cause of failure in the pre-act projects and was cited specifically or implicitly in half of the referenced studies we consulted, but it ranked fourth in frequency as a cause of failure in the post-act projects.

We have observed that specific motives and goals are appropriate and that others are inappropriate for an HMO. Applying this observation to requests for grant funds presents a real challenge to managers of the HMO program. An HMO is frequently viewed as a societal panacea. Interested groups in local areas are inclined to demand an opportunity to develop an HMO without reviewing the experiences in similar localities with HMOs. The challenge to the HMO staff is to present information at an early stage to interested groups in a form that will permit them to reassess their interest in putting together an HMO. This communication should occur before Federal funds are applied for and in light of what is already known about the potential viability of specific forms of HMOs in particular settings.

Difficulty in obtaining health care providers was the third most frequently cited cause for failure among the post-act projects. Provider issues were cited in 11 of the 13 referenced studies as a major factor affecting development or operational viability or both. The broad range of services mandated by the act and the statutory restrictions on how the services must be provided were identified as the reasons why sponsors of post-act projects were unable to secure providers to participate. These or similar requirements were not imposed on the pre-act projects.

Legal and financial requirements were identified in a majority of the references as fundamental factors affecting development. In neither the pre- nor post-act group of projects were these requirements frequent causes for stopping development. To date, not one post-act project has been judged unfeasible because of State legal barriers.

Community receptivity and participation were considered important by the authors of 9 of the 13 references. Lack of community support or opposition from those in the local area where the HMO was to be developed did not appear as a major factor in the termination of many post- or pre-act projects. It is likely that in the absence of local support, an approvable project application could not be prepared and that requests for Federal funds may have been discouraged by local forces in the early stages.

Consideration of the frequency of termination according to the type of sponsorship in the pre- and post-HMO Act periods will be deferred until final feasibility reports are received from the 108 grantees funded in fiscal year 1975. Similarly, comparisons of feasibility of nonmetropolitan projects in both periods will not be made until a majority of the 29 sponsors in nonmetropolitan areas that were awarded feasibility grants in fiscal 1975 have submitted final reports. Currently activity has been terminated in 9 of these 29 projects; the remaining 20 are still active. In a comprehensive study of 17 rural organizations completed in 1975, the probable effects of certain provisions of the HMO Act on the development of rural HMOs were analyzed (*23*). One conclusion was that few, if any, of the plans studied appeared likely to progress beyond the feasibility stage because of constraints mandated in the act that cannot be changed through regulations. A major finding was that "HEW is not likely to see a sizable increase in rural HMOs over the next several years unless some of the existing legislative and regulatory constraints are relaxed." As final feasibility reports are obtained from the 20 active nonmetropolitan projects, the results will be compared with those from the rural HMO study, and the implications for funding policies and legislative action will be identified.

Implications

We believe that this interim study on reasons for termination provides implications for future grant award policies, for program development, and for research.

Those who review grant requests in the future will need to assess the subjective factors that have been shown to be influential in the early stages of developing an HMO. Such assessments might take place during direct conversations with members of the board of directors of the sponsoring organization to determine the nature, realism, and depth of their interests in an HMO. Before approving a grant request, the existing or intended managers and medical leaders could also be evaluated to assess their professional experience in the projected tasks for which Federal funds are requested. Exploration of these considerations appears to be most appropriate for hospital-sponsored organizations and community plans sponsored by consumers. Assessment of the reasons why physician-sponsored organizations want to start an HMO could be made in the local setting. Physician-sponsored organizations interested in obtaining Federal funds to experiment with prepayment, to use an HMO to alleviate cash-flow problems, or to attract patients to a declining practice should be identified as rapidly as possible as inappropriately motivated groups.

Assessment of such subjective factors requires modification of grant review procedures. At present, reviewers typically determine the quality of a grant proposal on the basis of such factors as per capita income of the area's population, level of insured health benefits, and employer contributions to health insurance premiums. The reviewers are distant from the setting, and the applicant is not present during the review.

The implications for the future growth of HMOs in the nation focus on issues of management and medical manpower requirements. The shortage of appropriately trained persons to plan, develop, operate, and manage HMOs may limit the expansion of HMOs more than the availability of capital. Short-term training oriented to development of the skills of HMO staffs appears needed immediately. Also required are nondegree training, similar to the training program for HMO managers at the University of Pennsylvania's Wharton School, as well as more graduate programs in health care administration to prepare persons for careers in ambulatory health care agencies. Internships for managers and for health care staff in operating HMOs could supplement classroom training if funds to pay travel and stipends were identified.

Substantial modifications in the use of consultants by projects should also be considered as a means of strengthening the capabilities of project staff. If contracts with consultants provided for development of the staffs' skills, the staffs could learn by doing as they worked along with the consultant in financial planning and marketing.

The implications of this study for research focus on the need to identify and test the variables that could forecast the probability of failure before a great deal of public and private funds and effort have been expended. Wasserman has recently completed such a study on predictive variables (*24*).

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