asim

american society of internal medicine

September 10, 1996

Alexis Herman
White House Office of Public Liaison
Room 121 - Old Executive Office Building
Washington, DC 20201

Dear Ms. Herman:

The America Society of Internal Medicine is pleased to share with you the enclosed position papers on improving Medicare managed care and preserving the ability of managed care enrollees to obtain laboratory tests in their own doctors' offices.

"Reinventing Medicare Managed Care: Recommendations on Improving Choice, Access and Quality", calls on the federal government and managed care organizations to make changes that will improve choice, access and quality. Just as the federal government has mechanisms in place to protect patients from potential *overutilization* under fee-for-service Medicare, there is a need for improved standards to protect beneficiaries in managed care arrangements from potential *underprovision* of care.

ASIM's recommendations include providing more and better information to beneficiaries to help them choose a plan; streamlining the process for appeals of managed care denials; assuring adequate access to emergency care; protecting beneficiaries from financial arrangements that could lead to discrimination against sicker patients; improving internal and external quality improvement processes and standards; and adopting standards to assure sufficient access to--and choice of--physician. The recommendations are consistent with those made by the Institute of Medicine, U.S. General Accounting Office, the Physician Payment Review Commission, and private sector accrediting bodies. Despite recent efforts by the Health Care Financing Administration to hold managed care organizations to a higher level of accountability, more can and should be done.

In Reinventing Managed Care: Assuring Appropriate Access to Laboratory Testing for Patients in Managed Health Care, ASIM explains why patients enrolled in managed care organizations should have access to laboratory testing in their own physicians' offices. The paper's analysis is supported by expert studies that show that physician office labs offer patients the benefits of convenient, timely and high quality testing in their own doctor's office--at a price that is competitive with that of commercial laboratories. ASIM recommends that managed care organizations negotiate arrangements with physicians that permit access to in-office testing, rather than signing exclusive contracts with independent labs to perform all tests for enrollees.

ASIM welcomes your comments on the recommendations presented in our papers.

Sincerely,

Alan R Nelson MD

Alan Nelson, MD
Executive Vice President

2011 PENNSYLVANIA AVENUE, NW • SUITE 800 • WASHINGTON, DC 20006-1808
TELEPHONE: (202) 835-2746 • FAX: (202) 835-0443 • E-MAIL: asim@mem.po.com

ASIM

REINVENTING MANAGED CARE

Reinventing Medicare Managed Care: Improving Choice, Access and Quality

Recommendations of the American Society of Internal Medicine

September 1996

2011 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006-1808
(202) 835-2746
Fax: (202) 835-0443
E-mail: asim@mem.po.com

Reinventing Medicare Managed Care: Improving Choice, Access and Quality

Contents

Executive Summary

Issues	Proposals
Giving Patients and Their Physicians the Information Needed To Make Informed Decisions on Choice of Plans	The Secretary of Department of Health and Human Services (HHS) should require that a Medicare managed care organization (MCO) provide beneficiaries with information that explains its policies—formatted and written in the most easily understandable manner possible. MCOs also should disclose other information to help beneficiaries to make informed choices, including disenrollment rates; the number and percentage of claims for payment for services that were denied and later reversed upon appeal; participating physician turn-over rates; dollars spent on patient care and administrative costs; and the satisfaction of enrolled beneficiaries and of participating physicians with the MCO. HHS should direct the Secretary to develop a comparative information packet on the competing MCOs that Health Care Financing Administration (HCFA) would provide upon request to any Medicare beneficiary considering enrollment in an MCO.
Assuring Beneficiaries' Freedom To Choose the Physician Who Is Best Qualified To Treat Them	Medicare MCOs should meet standards concerning enrollee choice of physician, including a point-of-service rider option.
Assuring That Beneficiaries—Especially Those with Chronic Conditions and Special Needs—Have Timely and Convenient Access to the Full Range of Needed Physician Services	Medicare MCOs should be required to develop and implement standards for accessibility to hospital-based services, and primary and specialty care physician services. The processes for coordination of care and control of costs should not create undue burdens for enrollees with special health care needs or chronic conditions.
Assuring That Beneficiaries Have Immediate Access to Bonafide Urgent and Emergency Care	Medicare MCOs should consider a prudent layperson's assessment of a medical condition that requires treatment in an emergency room as one of the factors in determining when it should it pay for initial screening and stabilization, if necessary, in an emergency. The determination should be based on what is known by the patient at the time emergency care is sought, rather than what is learned as a result of the emergency room visit. HCFA should require MCOs with pre-authorization requirements for emergency and urgent care to comply with specific time frames for making such authorizations and on appeals of initial denials for urgent care.

Issues	Proposals
Assuring That MCOs Do Not Inappropriately Deny Payment for Beneficial Medical Services	Medicare MCOs should establish utilization review (UR) programs with the involvement of participating physicians, and should release to affected health providers and enrollees the screening criteria, weighting elements and computer algorithms used in reviews, and a description of the method by which these were developed; uniformly apply UR criteria that are based on sound scientific principles and the most recent medical evidence; use licensed, certified or otherwise credentialed health professionals in making review determinations and, subject to safeguards outlined by the Secretary, make available upon request the names and credentials of those conducting UR.
Assuring That the Methods Used by MCOs To Assess Physician Performance Are Designed and Implemented in a Manner That Will Not Compromise Access and Quality	Medicare MCOs should involve affiliated doctors in network management, and set up with participating provider input, provider performance evaluation measures; establish procedures for selection of health professionals based on objective standards of quality developed with suggestions and advice of professional associations, health professionals and providers; provide for review of applicants by committees with appropriate representation of each category and class of provider and written notification to provider applicants of any information indicating that the applying provider fails to meet the standards of the plan, along with an opportunity for the applicant to submit additional or corrected information. Economic profiling should be adjusted by taking into account a physician or health professional's patient characteristics (such as severity of illness) that may lead to unusual utilization of services. The results of such profiling should be made available to plan providers involved.

Issues	Proposals
Assuring That Internal and External Reviews of the Quality of Care Provided by MCOs Are Sufficient for Beneficiaries To Obtain Necessary and Beneficial Care	Medicare MCOs should be required to establish mechanisms to incorporate the recommendations, suggestions and views of enrollees, participating physicians and providers into the medical policies of the plan (such as policies relating to coverage of new technologies, treatments and procedures; quality and credentialing criteria; and medical management procedures); to monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions; to evaluate the continuity and coordination of care that enrollees receive, and to have mechanisms to detect both underutilization and overutilization of services. HCFA should check the effectiveness of a plan's quality assurance and utilization management processes and should include in that examination a systematic consideration of any peer-review organization (PRO) findings concerning the quality of the plan—using trained clinical evaluators. HCFA should require external review by an independent entity of each MCO's internal quality improvement procedures. In addition, HCFA should provide for private sector accreditation as an alternative to federal review and certification of MCOs.
Assuring That Beneficiaries Have Access to a Fair, Objective and Timely Process for Seeking Reconsiderations and Appeals of Denials for Medical Treatments, or To Have Other Grievances Addressed	Medicare MCOs and HCFA's own contractor for reviewing appeals should be required to meet appeals and grievance criteria that would reduce substantially the length of time from an initial determination to a final review by the independent contractor. Prompt review of emergency and urgent care, or complaints about inadequate access, should be required. Any contractor HCFA uses to review appeals of an MCO's decision to deny payment for otherwise covered services should be required to meet performance standards that are comparable to those required of Medicare Part B fee-for-service carriers.

Issues	Proposals
Assuring That Physician Incentive Payments Do Not Lead to Conflicts of Interest Between the Beneficiary and the Physician, Possibly Resulting in Inadequate Patient Care	HCFA should require MCOs that have financial incentive arrangements with physicians to provide adequate stop-loss coverage for physicians who are at substantial financial risk for services provided to Medicare and Medicaid enrollees. MCOs that pay physicians on an individual or group capitation basis should adjust their provider capitation payments to reflect the risk selection of the patients assigned to an individual participating provider, using such risk-adjustment methodologies as approved by the Secretary for this purpose. HCFA should improve its interim final rule on physician incentive plans to provide better stop-loss protection.
Assuring That Medicare Payments to MCOs Do Not Create Incentives for MCOs To Discriminate Against Sicker Patients with More Complex—and Costly—Illnesses	Congress should mandate that HCFA develop and implement a methodology to adjust payments to Medicare MCOs by the relative differences in the severity of illness of patients enrolled in each MCO.
Assuring That HCFA Adequately Enforces Current and Proposed Standards	Although approaches that emphasize continued quality improvement are preferable to ones that rely on punitive sanctions, HCFA should use its authority to impose sanctions against the MCOs for failure to provide medically necessary services required by a beneficiary, or for other major violations that can adversely affect quality and access. A graduated and increasing level of sanctions should be applied for each violation by a Medicare MCO.

Reinventing Medicare Managed Care: Improving Choice, Access and Quality

Introduction

The American Society of Internal Medicine (ASIM) believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsiderations of denied claims are heard in a timely manner. ASIM's conclusions are based on an intensive analysis of the current standards that apply to Medicare MCOs, the concerns expressed by several oversight agencies and advisory bodies about the inadequacy of the current standards, and a review of several legislative and regulatory proposals to improve federal oversight over Medicare MCOs. ASIM represents physicians who specialize in internal medicine—the nation's largest physician specialty and the one that provides medical care to more Medicare beneficiaries than any other.

Most analysts expect that enrollment in Medicare managed care arrangements will continue to increase rapidly....

Background

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 11 percent of beneficiaries belong to a Medicare managed care plan. With enrollment increasing at an annual rate of more than 25 percent—with a 41 percent increase in 1995 from the previous year—most analysts expect that enrollment in Medicare managed care arrangements will continue to increase rapidly in the foreseeable future. Some analysts believe that managed care soon will replace fee-for-service (FFS) as the dominant form of delivering services to Medicare beneficiaries.

Both the administration and Congress are in the process of instituting reforms that are likely to further accelerate enrollment in Medicare managed care arrangements. The administration's new Medicare Choices demonstration project will allow beneficiaries in communities that currently do not have substantial enrollment in managed care to join MCOs that offer more flexibility than traditional HMOs and CMPs, such as preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and point-of-service (POS) plans. Since PPOs, POS plans and many PSOs give patients the option of receiving services outside of a health plan's network of providers, they offer a wider choice of physicians than conventional staff-model or network HMOs. The expanded freedom of choice provided by such arrangements is likely to attract beneficiaries who otherwise would be unwilling to join a managed care plan. Incentives to expand enrollment in MCOs is a lynchpin of the Medicare reform proposals that the 104th Congress has considered. Should reforms similar to those proposed in the Balanced Budget Acts of 1995 and 1996 ultimately be enacted into law, the transition from Medicare fee-for-service to Medicare managed care will be further accelerated.

With increased enrollment, there is an increased need for the federal government to exercise appropriate oversight over the care provided to Medicare beneficiaries

who are enrolled in MCOs. Unfortunately, despite some recent efforts to make improvements, the federal government is not doing an adequate job of exercising oversight over the care provided to the more than 3 million beneficiaries who are currently enrolled in the 150-plus HMOs and CMPs that now participate in the program. There is considerable evidence to support the conclusion that despite recent improvements, the existing federal certification standards for Medicare MCOs need improvement, even though a relatively small number of beneficiaries are now enrolled in MCOs. Major improvements will clearly be needed as the number and types of plans—and the number of enrollees—increase rapidly over the next several years.

The Institute of Medicine (IOM) of the National Academy of Sciences issued a report in July 1996 that supports the need for major improvements in the standards applied to Medicare MCOs. The authors of the report observed that:

> As major efforts to shift Medicare patients into managed care plans move forward, many experts and patient advocates are concerned whether the necessary information and protections are in place to enable beneficiaries to select an appropriate health plan wisely and to ensure that this group continues to have access to high quality health care. The potentially daunting scope and speed of the transition by elderly Americans into what for most beneficiaries remains uncharted waters makes the need for high-quality, trustworthy information and accountability particularly critical. Only by laying a solid infrastructure in which individuals can make informed purchasing decisions and which competition is based on quality performance can the public confidence needed to move Medicare beneficiaries safely and responsibly into a marketplace for choice and managed care be ensured.

Other recent reports have reached similar conclusions on the need to improve the standards that apply to Medicare MCOs. In August 1995, the General Accounting Office (GAO)—a watchdog arm of Congress—issued a report that concluded the following:

> Although the Health Care Financing Administration (HCFA) has instituted several promising improvements, its process for monitoring and enforcing Medicare HMO performance standards continues to suffer from three significant limitations:
>
> - *Quality assurance reviews are not comprehensive.* Even HMOs with many serious documented quality problems were not found to be out of compliance with requirements by HCFA's routine monitoring. HCFA routinely reviews the HMO's descriptions of its quality assurance processes—it does not check to see whether HMOs implement those processes effectively....
>
> - *Enforcement actions are weak.* When HCFA has documented problems in HMOs that have been slow to correct deficiencies, it has been reluctant to use sanctions and other enforcement tools at its disposal. Under HCFA's enforcement approach, serious improprieties by a few Medicare HMOs—subjecting beneficiaries to abusive sales practices, unduly delaying their appeals, or exhibiting patterns of poor-quality care—have taken years to resolve.

The existing federal certification standards for Medicare MCOs need improvement....

- *The appeals process is slow.* Beneficiaries who appeal HMO denials often wait six months or more for resolution. The consequences for beneficiaries may include prolonged uncertainty, high out-of-pocket costs, and having to disenroll from an HMO to obtain services.

GAO also noted that "HCFA's current regulatory approach to ensuring good HMO performance lags behind the latest private sector practices." As noted later in this report, the GAO reiterated its concerns in a second follow-up report that was issued in April 1996, taking into account recent efforts by HCFA to improve its oversight of Medicare MCOs.

The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) surveyed a stratified sample of 4,132 enrollees and disenrollees from 45 Medicare risk HMOs. Although OIG concluded that "generally, beneficiary response indicates Medicare risk HMOs provided adequate service access for most beneficiaries who had joined," it also found that "compliance with federal enrollment standards for health screening and informing beneficiaries of their appeal rights appeared to be problematic," "some enrollees experienced noteworthy delays" in receiving timely appointments for primary and specialty care, "disenrollees reported more problems with access to primary and specialty care" than enrollees, "disenrollees were more likely to perceive unsympathetic behaviors that potentially restrict service access," and "overall, HMO beneficiaries seemed relatively healthy; however, disenrollees rated their health lower than enrollees and reported a much greater decline in health status during their HMO stays."

'Consumer protection requirements to foster quality of care should apply to all plans that serve Medicare beneficiaries.'

– Physician Payment Review Commission

The Physician Payment Review Commission (PPRC), in its 1995 report to Congress, recommended that HCFA "make performance reports on the managed care plans that contract with the Medicare program available to beneficiaries to inform their choices . . . ." In its 1996 report to Congress, PPRC expanded on its recommendations for holding Medicare MCOs accountable:

- All health plans that serve Medicare beneficiaries should be subject to the same standards to promote quality of care. Specific methods for meeting those standards may differ as appropriate, depending on plan design.

- Medicare restructuring legislation should require all health plans serving Medicare beneficiaries to participate in an audited system of consumer-oriented performance reporting that emphasizes measures of health care quality.

- All health plans that serve Medicare beneficiaries should be required to maintain an internal quality assurance program. Medicare's requirements for these quality assurance programs should be consistent with established private sector requirements, where they exist, and should reflect differences in plan design as appropriate.

- All health plans that serve Medicare beneficiaries should be subject to external quality review by an independent entity approved by the Department of Health and Human Services. Plans' internal quality assurance programs should be subject to periodic external review to verify that they meet established standards.

- Consumer protection requirements to foster quality of care should apply to all plans that serve Medicare beneficiaries. Plans should be required to maintain procedures for beneficiary appeals of plan decisions not to provide or pay for a service, for timely resolution of beneficiary and provider grievances, and for notification of beneficiary rights and responsibilities.

PPRC's report does not specify whether the external review should be conducted by Medicare peer review organizations (PROs), private sector accreditation entities such as the National Committee for Quality Assurance (NCQA), or some other entity.

The Institute of Medicare report mentioned earlier cites several other studies that support the need for the Health Care Financing Administration and Congress to make major improvements in the federal government's approach to improving choice, access, and quality in Medicare managed care.

HCFA's Efforts To Improve Quality in Medicare Managed Care

To its credit, HCFA is beginning to develop better ways to assure adequate quality and access in Medicare MCOs. The agency's Health Care Quality Improvement Program (HCQIP) is intended to emphasize outcomes and improvement in quality of care—borrowing from outcome-based and continuous quality improvement (CQI) models that increasingly are being applied to private sector MCOs. The HCQIP program has, for example, dramatically improved the way the Medicare PROs review care in the fee-for-service setting, de-emphasizing chart-by-chart review that was intended to "single-out poor performers after the fact to one of quality improvement, promoting good practices, and continually identifying opportunities for improvement" [Statement of the American Medical Peer Review Association to the Ways and Means Committee, March 31, 1995].

HCFA also is a participant in the Foundation for Accountability (FAcct). FAcct was founded by large corporate purchasers of health care, with the goal of developing a new generation of quality measures for health plans to provide purchasers and consumers with relevant information for health care decision-making. HCFA's goal is to integrate outcome-based performance measures into its Medicare MCO certification program.

The agency also is a participant in the development of the next generation of the Health Plan Employer Data and Information Set (HEDIS 3.0), a set of performance measures developed by NCQA. Previous versions of HEDIS were intended principally for employers to use in comparing the performance of health plans in the private sector. HEDIS 3.0 "is weaving together the interests and concerns of all three payer populations—commercial, Medicare and Medicaid—to create a comprehensive set of performance measures" [NCQA World Wide Web notice]. The HEDIS 3.0 draft standards were released in July, 1996 for public review and comment.

HCFA's goal is to integrate outcome-based performance measures into its Medicare MCO certification program.

HCFA is also funding a pilot project to develop a method for assessing the care of Medicare beneficiaries who receive their care from managed care organizations. The Delmarva Foundation for

Medical Care (Delmarva)—the PRO for Maryland and the District of Columbia—together with Harvard University has developed performance measures that are being pilot tested in several states. HCFA intends to use the results of the pilot project to develop and implement performance measures for managed care organizations that contract to provide care to Medicare beneficiaries.

Finally, HCFA officials have stated their desire to make changes in the standards governing appeals and coverage of urgent and emergency room care to address the concerns that have been raised about the current requirements. HCFA also has stepped up its enforcement against plans that fail to meet the current standards, including the imposition of intermediate sanctions on some MCOs.

Further Improvements Still Needed

IOM's study embraced the notion that the federal government has a responsibility to hold all Medicare plans...accountable.

Despite such efforts, however, HCFA's approach to holding Medicare MCOs accountable for quality and access to services still suffers from significant deficiencies, according to GAO's most recent analysis, published in April 1996. While crediting HCFA for its efforts to improve the Medicare MCO certification program, GAO concluded that HCFA's qualification program for HMOs remains inadequate for the following reasons:

- HCFA does not determine whether HMO quality assurance programs are operating effectively. HCFA's routine compliance monitoring reviews do not go far enough to verify that HMOs monitor and control quality of care as federal standards require. The reviews check only that HMOs have procedures and staff capable of quality assurance and utilization management—not for effective operation of these programs.

- HCFA does not systematically incorporate the results of PRO review of HMOs or use PRO staff expertise in its compliance monitoring.

- HCFA does not routinely collect utilization data that could most directly indicate potential quality problems. In the fee-for-service sector, claims data are available and can be used to detect potential overutilization of services. Although HCFA has the authority to require HMOs to collect such data . . . no comparable data exist for use in the Medicare HMO qualification program to detect potential underutilization.

- HCFA does not evaluate HMO risk-sharing arrangements with providers.

[Note: Since the GAO report was issued, HCFA has issued final rules governing such arrangements. For reasons discussed later in this report, the regulation does not go as far as it should in protecting beneficiaries from financial incentives to underserve patients.]

GAO also " found that enforcement processes remain slow when HCFA does find quality problems or other deficiencies at HMOs that do not comply promptly with standards." Finally, GAO found that "HCFA does not routinely release its site visit reports to the public."

Although HCFA advised GAO that it intends to have an outside contractor perform annual surveys of a statistically valid sample of Medicare enrollees in every Medicare MCO—using a standard survey and consistent analysis of the information received from beneficiaries—HCFA had not yet begun the contracting process. The intent is for the surveys to include information on member satisfaction, quality of care, and access to ser-

vices. HCFA will use the data to monitor HMOs as well as to translate the resulting data into information that will be meaningful to beneficiaries. GAO concluded, however, that "HCFA's plans and timetable for implementing patient satisfaction measurement information lag behind those of some private sector employers and state agencies because HCFA does not believe it has useful information to give to beneficiaries. We agree that HCFA should proceed with due care . . . however, other responsible purchasers already have proceeded with surveying constituents to determine their feelings about their health care and have published satisfaction data and other performance information to help individuals make purchasing decisions."

The Institute of Medicine similarly concluded that substantial improvements are needed in Medicare's requirements as they relate to disclosure of information to beneficiaries, development of performance based measures, external oversight of quality, coverage of emergency care, timeliness of appeals, and other elements addressed in this paper. The IOM's study specifically embraced the notion that the federal government has a responsibility to hold all Medicare plans—including managed care arrangements—accountable:

> For the purpose of this report, the committee selected to define *public accountability* as accountability to the public, defining *public* as beneficiaries in the first instance, but also the larger public as interested parties and taxpayers, and to define government as the elected representatives of the citizenry. Although public accountability may mean different things to different people, most would accept the basic premise that managed care (choice) plans should be held accountable to both Medicare beneficiaries and to the public at large: to Medicare beneficiaries because of the contractual arrangements between managed care plans and their Medicare enrollees and to the general public because it pays...for the care that is provided... the committee discussed some additional elements of public accountability and determined that these should include the following:
>
> - Requirements for disclosure and the dissemination of useful information,
> - The capacity to assess and report whether contracted services are performed responsibly and effectively,
> - Requirements as a public program financed by taxpayer dollars to see that the needs of individuals are balanced against the wise use of collective resources,
> - A special level of responsibility as the purchaser of health care for elderly beneficiaries, many of whom are vulnerable.

ASIM supports the IOM's fundamental conclusion that the federal government must hold Medicare managed care plans accountable to the public. The recommendations in this paper outline an approach for improving accountability while avoiding excessive regulations and micromanagement that could stifle innovation in the market.

Internists believe that MCOs must hold more accountable for their impact on the care of patients with ...more chronic and complex illnesses....

Principles Underlying ASIM's Recommendations

The federal government has placed much emphasis on assuring that there are consumer protections against the potential for underutilization.

ASIM's goal is to identify a reasonable set of standards for MCOs that contract to provide services to Medicare and Medicaid beneficiaries. Such standards should be designed to make Medicare-Medicaid MCOs more accountable for their impact on the access to—and quality of—medical care that is provided to enrollees. Internists believe that MCOs must be held more accountable for their impact on care of patients with the more chronic and complex illnesses typically treated by internists and IM subspecialists, since those patients are most at risk of seeing access to—or quality of—care compromised under some managed care arrangements.

The proposed standards are based on the following principles:

1. The federal government should be as concerned about the potential for underprovision of needed services in Medicare MCOs as it is about potential overutilization in the Medicare FFS program. The federal government has extensive rules and procedures to protect FFS beneficiaries from potential *overutilization*—including prepayment screens, coding edits, medical necessity review, and postpayment review and audits—that may occur because of the incentives in FFS to provide more services to beneficiaries. It does not appear that the federal government has placed much emphasis on assuring that there are reasonable consumer protections against the potential for underutilization—for example, patients being denied access to beneficial tests or to the physicians who are best qualified to treat them—that are present whenever a health plan is placed at financial risk for the services it provides to patients. Medicare should avoid a micromanagement approach to assuring that appropriate care is provided, both in the FFS and managed care settings. But Medicare can and should do more to assure that MCOs have safeguards in place to protect against underutilization—subject to oversight by the federal government and other independent review entities, such as PROs.

2. Although Medicare currently has specific requirements relating to the process and timeliness of appeals and reconsiderations of denied services, improvements can and should be made to improve the timeliness and process of review.

3. Beneficiaries should be provided with accurate, understandable and balanced information to enable them to make an informed choice between FFS and managed care, as well as among the managed care options that are available to them.

4. The quality and access standards that apply to each MCO, as well as the methods of reimbursement to Medicare MCOs, need to be designed to protect patients with more complex and costly illnesses from discriminatory treatment by the MCO.

ASIM intends for its recommendations to be used in the following ways:

1. HCFA should consider incorporating these recommendations into its HMO qualification program. HCFA already is considering implementing approaches—such as providing beneficiaries with more information to help them make informed choices—that are similar to those proposed in this paper. The agency is also working on the development of performance- and outcome-based measures for Medicare MCOs. It reportedly also is looking at ways to streamline the appeals process and to clarify its policies on provision of emergency room and urgent care services. ASIM believes, however, that the agency can move more quickly on implementing many of the changes proposed in this paper. It should move faster to incorporate the proposed disclosure and reporting requirements into its qualification program. There are data already available to HCFA, such as disenrollment rates by plan, that can and should be provided now, even as more extensive reporting mechanisms are developed. Further, the specific types of data ASIM believes should be reported to both patients and physicians go considerably beyond HCFA's current plans on disclosure. Similarly, HCFA can and should make it a higher priority to bring about prompt implementation of changes to improve the review and appeals process, to require external oversight of MCOs' internal quality improvement procedures, and to clarify policy on emergency and urgent care.

2. To the extent that HCFA is unwilling or lacks the legal authority to institute the proposed changes, Congress should consider mandating them.

3. The managed care industry should begin to institute voluntarily the changes—recommended by ASIM, PPRC, GAO and others—that are within their control, such as disclosing more information to prospective enrollees, modifying precertification requirements and speeding up the time frame for reviewing requests for reconsiderations. Although clear federal requirements will be needed to assure consistent performance across competing MCOs, there is no reason that MCOs cannot on their own begin to implement many of the changes proposed in this paper.

Medicare should avoid a micromanagement approach to assuring that appropriate care is provided.

Recommendations

Giving Patients and Their Physicians the Information Needed To Make Informed Decisions on Choice of Plans

I. ASIM believes that information described below should be disclosed to enrollees and potential enrollees prior to enrollment, at least once annually thereafter, and at any time that the MCO substantially modifies its established rules or policies. (Note: The current standards applying to Medicare MCOs are in regular type; ASIM's proposed additions and modifications are presented in italics.)

A. Require MCOs to provide beneficiaries with information *written and formatted in the most easily understandable manner possible* that explains:

1. Written rules and policies regarding benefits;
2. How and where to obtain services from or through the MCO;
3. Restrictions on coverage for services furnished outside the MCO, *including the extent to which enrollees may select the providers of their choice (from within or outside the plan's network of providers if applicable), and the restrictions (if any) on payment for services furnished to the enrollees by providers other than those participating in the plan;*
4. The obligation of the MCO to assume financial responsibility and to provide reasonable reimbursement for emergency services and urgently needed services;
5. Any services other than emergency or urgently needed services that the HMO or CMP chooses to provide;
6. Premium information;
7. Grievance and appeal procedures *including the right to address grievances to the Secretary of HHS or the applicable review entity*;
8. Disenrollment rights;
9. *Any restrictions that limit coverage to prescription drugs approved by the MCO (i.e., drug formularies);*
10. *Any prior authorization requirements for inpatient admissions, elective procedures or referrals;*
11. *Any rules that require beneficiaries to obtain authorization from a primary care physician (PCP) to cover referrals for tests, elective procedures and specialty care; and*
12. *Any rules that limit access to clinical laboratory tests performed in participating physicians' offices.*

B. *Require MCOs to inform beneficiaries of their right to be informed about various treatment options including:*

1. The right to discuss with their physician the advisability of seeking treatment options that may

not be available through the MCO or for which the MCO will not authorize coverage; and

2. The right to decline treatment.

C. *Require MCOs to disclose their disenrollment rates for Medicare enrollees for the previous two years (excluding disenrollment due to death or moving outside of the plan's Medicare service area).*

D. *Require MCOs to disclose the number and percentage of claims for payment of services for the previous two years that were denied by the plan and appealed to the Secretary of HHS, an administrative law judge, or federal court under the appeals procedures that are available to beneficiaries; and disclose the number and percentage of such denials that were reversed upon appeal.*

E. *Require MCOs to disclose the number and percentage of participating providers for the prior three years whose contracts with the MCO were not renewed by action of the MCO or the provider.*

F. *Using a standard reporting format as required by the Secretary, require MCOs to disclose their medical expense ratio. A medical expense ratio represents the proportion of total revenue spent on medical services, as opposed to the proportion spent on administrative expenses, retained or distributed to owners.*

G. *Require MCOs to disclose any restrictions placed on the information that participating providers are allowed to discuss with or otherwise communicate to beneficiaries.*

H. *Using a standard reporting format as required by the Secretary, require that the MCO provide a report card on the satisfaction of enrolled beneficiaries and participating physicians with the plan. As a basis for preparing such report cards, require MCOs to use a standard survey instrument (as specified by the Secretary) to survey beneficiaries and their participating physicians at least once annually on their satisfaction with the MCO—including assessments by enrolled beneficiaries and by participating providers of the quality of care provided, and the ease by which beneficiaries can access needed services and obtain care from physicians who are most qualified to treat them.*

I. *Require MCOs that have physician incentive plans (as defined by current regulations) provide a written disclosure—based on standard definitions and explanations as established by the Secretary of HHS—of the impact that such arrangements can have on patient care, including the financial incentives that are created for providers to provide fewer services to beneficiaries. The recently released physician incentive plan regulations need to be improved by standardizing the information that must be provided to patients, rather than leaving it to the plans to decide on the wording and content of the disclosure statements.*

II. Congress should direct the Secretary of HHS to develop a comparative information packet on the competing MCOs. HCFA would provide the packet—upon request—to any Medicare beneficiary who is considering enrolling in an MCO.

The information packet must be written and formatted in the most easily understandable manner possible. At a minimum, the information packet should include: comparative data per plan on rates of disenrollment, dollars spent on patient care and administrative costs, the number of grievances/complaints filed with HCFA, standardized surveys of participating physician and enrollee satisfaction with each plan, any sanctions imposed by HCFA for violations of an MCO's contract with the agency during the prior three years, and the percentage of participating provider contracts with the MCO that are not renewed each year for the prior three years. Mandate that such information packets be available in all localities for which beneficiaries have a choice of MCOs no later than Jan. 1, 1999.

Beneficiaries have a right to know about cost-saving internal policies...that can restrict access to certain services.

Explanation: The underlying premise behind offering beneficiaries a choice of enrolling in MCOs is that competition between health plans can result in better care at lower cost to the Medicare program and to patients. Competition can be effective, however, only if beneficiaries are given the information needed to assess the merits of remaining in FFS or enrolling in MCOs, and to compare the different Medicare MCOs that are available to them. As the IOM observes:

> Without adequate, reliable, comparable, and timely information, it is not possible to exercise informed choice.

ASIM believes that beneficiaries must have a right to know about cost-saving internal policies and financial arrangements used by some MCOs that can restrict their access to certain services. Further, such information must be presented in the most easily understandable manner possible, as was proposed in the FY'96 conference agreement on Medicare budget reconciliation. The conference agreement also included recommendations, similar to those proposed by ASIM, on disclosing information on the extent to which patients may select the providers of their choice from within or outside the plan's provider network and on restrictions on payment for services furnished by providers other than those participating in the plan, and on disenrollment rates for the past two years. The president's FY'97 Medicare Expanded Choice proposal supports the recommendations to require that MCOs inform beneficiaries of their right to be informed about various treatment options and their right to decline treatment. The recommendation that the Secretary prepare comparative report cards on MCOs is consistent with recommendations made by PPRC in its 1995 and 1996 reports to Congress.

Although some managed care organizations may resist more detailed disclosure requirements, disclosure can have a positive impact on reducing disenrollments from health plans. According to the IOM:

> One way to curb disenrollments is to focus on providing enrollees with as much information as possible up front so that enrollees understand how the plan works, what their expected out-of-pocket expenses will be, the benefit structure, how out-of-plan care is handled and what constitutes an emergency. The plan's responsibilities and

members' rights need to be fully outlined in terms that are easily understood . . . Studies indicate that the plans with the lowest rates of rapid disenrollment spend a great deal of time educating potential new enrollees up front.

The IOM agreed with many of the recommendations presented by ASIM in this paper on the types of information that should be divulged to beneficiaries, including

- Enrollment and disenrollment rates;
- Comparative performance on clinical, structural, and satisfaction benchmarks;
- Access measures, including the percentage of referrals denied or unavailable;
- Physician turn-over rates;
- Satisfaction measures (specifying those with chronic conditions) including disenrollment information,
- Appeals and grievance procedures, including the numbers, reasons, and resolutions of grievances and appeals per MCO;
- Access and quality findings from HCFA monitoring surveys;
- Information on how referrals are made, including who makes the referrals and on what basis;
- Appeals and grievance systems; and
- Financial and contractual arrangements between plans and providers that may influence their decisions regarding services in the judgment of the federal government.

Assuring Beneficiaries' Freedom To Choose the Physician Who Is Best Qualified To Treat Them

Medicare MCOs should meet the following standards concerning enrollee choice of physician:

A. Enrollees should be able to select a personal physician from among all participating plan physicians.

B. If a plan limits benefits to items and services furnished only by providers in a network of providers which have entered into a contract with the sponsor, the sponsor must also offer at the time of enrollment a POS rider to cover items and services furnished by health professionals who are not participating providers. A supplemental premium could be charged for such a rider and cost-sharing rules imposed by the MCO for out-of-plan services.

C. For the POS option, the HHS Secretary should establish an actuarially sound schedule of limits on cost sharing for out-of-plan items and services. These cost-sharing limits must be applied uniformly to all POS offerings. Cost-sharing for such items and services for lower-income enrollees should be appropriately lower than limits established by the Secretary for other enrollees and should be set at a level that would not pose an unacceptably large financial burden to obtaining out-of-network services. For purposes of cost-sharing, lower-income enrollees are defined as individuals who have adjusted gross in-

come below 250 percent of poverty level.

Explanation: Medicare regulations currently require health plan contracts to allow each enrolled recipient to choose a health professional in the HMO or PHP "to the extent possible and appropriate." Beginning Jan. 1, 1997, MCOs will be able to offer a POS option to enrollees. However, as managed care assumes a larger role in Medicare, many beneficiaries will be exposed to its requirements and regulations for the first time. Many of these same beneficiaries will have chronic or disabling illnesses that may make them vulnerable to pressures to control costs and utilization that often are linked to managed care. By giving these enrollees an option to go outside a health plan's network of providers, with imposed limits on cost-sharing, beneficiaries who are most likely to be dissatisfied with a plan because of their unfamiliarity with managed care will have an outlet for that dissatisfaction.

Many Medicare beneficiaries are being exposed to managed care's requirements and regulations for the first time.

Assuring That Beneficiaries—Especially Those with Chronic Conditions and Special Needs—Have Timely and Convenient Access to the Full Range of Needed Physician Services

Medicare MCOs should be required to:

A. Develop and implement standards for accessibility to hospital-based services and to primary and specialty care physician services. These accessibility standards shall ensure that the plan establishes and maintains adequate arrangements with a sufficient number, mix and distribution of health professionals and providers to assure that items and services are available to each enrollee in the service area of the plan; in a variety of sites of service; with reasonable promptness (including reasonable hours of operation and after-hours services); with reasonable proximity to the residence and workplace of enrollees; and in a manner that takes into account the diverse needs of enrollees and that reasonably assures continuity of care.

B. Develop and implement standards to allow for the addition of providers to meet patient needs based on increases in the number of enrollees, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

C. Develop and implement standards to ensure that processes for coordination of care and control of costs do not create undue burdens for enrollees with special health care needs or chronic conditions.

Explanation: MCOs currently are required to arrange for or provide basic health services for which enrollees have contracted within the HMO service area. Medicare's current standards, however, are not as specific as those required by some private sector accrediting bodies. Given that Medicare patients tend to be older, sicker and have more chronic conditions than non-Medicare patients, it is especially important that Medicare MCOs demonstrate that they have standards of accessibility that are at least as stringent as those required by private sector accrediting bodies. ASIM's recommendations are derived in part from existing private sector standards used to accredit commercial managed care plans (e.g., Utilization Review Accreditation Commission standards 4.0-5.2). By incorporating these standards into the Medicare program, beneficiaries will be assured that their health plans meet the same access standards as those required of plans in the private sector.

The Institute of Medicine also has called for new conditions of participation for Medicare MCOs that would include guarantees of sufficient access to the full range of physician services that beneficiaries may require to treat their medical conditions:

> [Medicare choice plans should] have resources, including appropriate mixes of specialists and referral services, to provide benefits throughout the service areas to a reasonable degree defined by the federal government so as not to divide metropolitan areas or counties except when natural barriers or other conditions divide service areas.

Assuring That Beneficiaries Have Immediate Access to Urgent and Emergency Care

Medicare MCOs should demonstrate that they have standards of accessibility that are at least as stringent as those required private sector accrediting bodies.

Medicare MCOs should:

A. Use a prudent layperson's assessment of what constitutes an emergency condition as one of the factors in determining when it should pay for initial screening and stabilization in the emergency room. The determination should be based on what is known by the patient at the time the emergency care is sought, rather than what is later learned as a result of the emergency department visit. Additional evaluation and treatment services should be provided consequent to a medical professional's screening, so a different standard would apply to coverage of such services.

B. Make timely decisions on requests for preauthorization of emergency and urgent care services. (See recommendations on improving the reconsideration and appeals process for specific, recommended time frames for review of emergency and urgent care.)

Explanation: HCFA has only broad requirements that plans make appropriate emergency care available to enrollees. HCFA does not specify how plans should treat requests for emergency services. The Physician Payment Review Commission, in its 1996 report to Congress, recommended use of a "prudent layperson"

HCFA does not specify how plans should treat requests for emergency services.

standard as one factor in determining coverage of initial screening and stabilization in the emergency room, based on what is known by the patient at the time the emergency care is sought, rather than what is learned as a result of the emergency department visits. Adoption of this standard would prevent circumstances in which patients must evaluate whether their illness is a medical emergency or risk denial of payment for emergency room costs—or find after the fact that symptoms that led them to reasonably conclude that a medical emergency existed were later denied by the MCO because it subsequently determined the condition was not an emergency. For example, a beneficiary with shortness of breath who is concerned that he or she may be having a cardiac emergency should not be penalized if it is later determined that the patient was not at risk of having a heart attack.

Concern about how MCOs handle requests for approval of emergency care was also expressed by the IOM. The IOM recommends that:

> ...the federal government [should] make available an expedited review and resolution of the process for Medicare choices (by an agency independent of the health plan and the traditional Medicare program) to review emergency situations, such as the following (1) when a situation is life-threatening; (2) when the time involved to review the appeal under the usual process would result in loss of function or a significant worsening of the condition or would render the treatment ineffective; or (3) when advanced directives or end-of-life preferences are involved.

Assuring That MCOs Do Not Inappropriately Deny Payment for Beneficial Medical Services

Medicare MCOs should:

A. Establish utilization review (UR) programs with the involvement of participating physicians and release to affected health providers and enrollees the screening criteria, weighting elements and computer algorithms used in reviews and a description of the method by which these were developed.

B. Uniformly apply UR criteria that are based on sound scientific principles and the most recent medical evidence.

C. Use licensed, certified or otherwise credentialed health professionals in making review determinations and, subject to safeguards outlined by the Secretary, make available upon request the names and credentials of those conducting UR.

D. Be explicitly prohibited from compensating individuals conducting UR based on numbers of denials.

E. Treat favorable preauthorization reviews as final for payment purposes unless the determination was based on fraudulent information supplied by the person requesting the determination.

F. Provide timely access to review personnel and, if such personnel are unavailable, waive any preauthorization that would be otherwise required.

Explanation: Medicare is a public program and the development and operation of review criteria and policies should be subject to public scrutiny. Furthermore, beneficiaries have a right to expect that their care is being judged on sound medical bases and not merely on cost considerations. Under the FFS side of Medicare, carrier utilization screens and criteria are usually available for review by physicians and consumers. Carriers are also required to solicit comments from state medical societies and specialty societies about proposed changes relating to the review of the medical necessity of covered services under Medicare Part B. They are also required to consult with state carrier advisory committees that include representatives of physicians and other Medicare providers.

Unfortunately, no such requirements exist for Medicare MCOs. ASIM believes that it is essential that participating plan physicians be involved in examining the utilization review guidelines and policies of Medicare MCOs to determine if medical necessity determinations are being made appropriately. If MCOs are able to keep secret the criteria by which they make coverage decisions, there is an increased potential for legitimate medical care to be denied arbitrarily and incorrectly.

Assuring That the Methods Used by MCOs To Assess Physician Performance Are Designed and Implemented in a Manner That Will Not Compromise Access and Quality

Medicare MCOs should:

A. Involve affiliated doctors in network management, and set up—with participating provider input—provider performance evaluation measures.

B. Establish procedures for selection of health professionals based on objective standards of quality that would take into consideration suggestions by professional associations, health professionals and providers.

C. Provide for review of applicants by committees with appropriate provider representation, and written notification to provider applicants of any information indicating that the applying provider fails to meet the standards of the plan, along with an opportunity for the applicant to submit additional or corrected information.

D. Use objective criteria when taking into account economic considerations in the selection process, and make such criteria available to those professionals applying to participate.

Beneficiaries have a right to expect that their care is being judged on sound medical bases and not merely on cost considerations.

E. Adjust economic profiling by taking into account a physician's or health professional's patient characteristics (such as severity of illness) that may lead to unusual utilization of services, and make the results of such profiling available to plan providers involved.

F. Provide potential participating providers with the plan's contracting standards and criteria.

G. Involve participating physicians in developing written policies for disciplinary action and sanctions.

H. Unless the physician poses an imminent harm to enrollees, provide:

   1. A 90-day notice of a determination to terminate a physician contract "for cause;"

   2. An opportunity to review and discuss all of the information on which the determination is based;

   3. An opportunity to submit supplemental and corrected information; and

   4. An opportunity to enter into a corrective action plan.

I. Not include in its contracts with participating physicians a provision permitting the MCO to terminate a contract "without cause."

Participating physicians should consulted on credentialing standards and informed of their own performance relative to plan standards.

Explanation: HCFA regulations do not appear to address specifically requirements concerning credentialing of providers or measurement of provider performance. However, indirect references to MCOs providing for review of the processes in which health services are delivered, and collection of data regarding organizational performance and patient results would imply the necessity for the MCOs to engage in credentialing and provider performance measurement activities. Given requirements of private sector accreditation programs concerning credentialing of plan providers, such as those devised by the Utilization Review Accreditation Commission, ASIM believes that similar standards should be incorporated into the Medicare program and recommends that participating physicians should be consulted on credentialing standards and informed of their own performance relative to plan standards. In addition, participating physicians should be given a chance to improve performance before adverse actions are taken—except in cases of imminent harm to patients. Such standards also would ensure that patients who may have longstanding relationships with a particular physician are not suddenly deprived of that physician's services due to an adverse action by an MCO. This would be especially important for frail or chronically ill elderly patients whose conditions require the knowledge and historical experience of their physician to receive optimum care.

ASIM's recommendations would not limit the ability of MCOs to contract selectively with physicians, to require appropriate credentials, or to make decisions on selection and de-selection based on performance criteria, including criteria relating to quality, patient satisfaction, and cost-effectiveness. The recommendations would put the appropriate emphasis on collaborating with physicians to improve quality, rather than using a secretive and punitive approach to assessing physician performance. Without some assurance that MCOs will base their assessments on objective criteria that has credibility

to physicians, and that individual physicians' performance profiles will take into account differences in the severity of illness of the patients being treated, there is a grave risk that some MCOs will arbitrarily exclude highly qualified physicians from participation in the plan—especially physicians who have a sicker patient population.

Assuring That Internal and External Reviews of the Quality of Care Provided By MCOs Are Sufficient for Beneficiaries To Obtain Necessary And Beneficial Care

I. Medicare MCOs should be required to:

A. Establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians and providers that improve quality of care into:

   1. Medical policies of the plan (such as policies relating to coverage of new technologies, treatments and procedures;

   2. Quality and credentialing criteria of the plan; and

   3. Medical management procedures of the plan.

B. Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.

C. Evaluate the continuity and coordination of care that enrollees receive.

D. Have mechanisms to detect both underutilization and overutilization of services.

E. Use systematic data collection of performance and patient results, provide interpretation of these data to its practitioners, and make needed changes.

F. Make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Explanation: HCFA currently requires health plans to have "an ongoing quality assurance program" that stresses health outcomes to the extent consistent with the state of the art and that provides for review by physicians and other health professionals of the process followed in the provision of health services. MCOs also should have written procedures for taking appropriate remedial action whenever—as determined under the quality assurance program—inappropriate or substandard services have been provided, or services that ought to have been furnished have not been provided. However, further elaboration of the content of health plan quality assurance programs, as outlined in last year's Balanced Budget Act and in H.R.2400, (the Family Health Care Fairness Act), would ensure that managed care plans take all steps necessary to assure a high level of quality in their delivery of health care services.

There is a grave risk that some MCOs will arbitrarily exclude highly qualified physicians...who have a sicker patient population.

II. HCFA should:

A. Require MCOs to regularly report patterns of utilization of services, availability of such services and other information to track utilization, access and satisfaction of enrollees.

B. As recommended earlier, routinely publish comparative data collected on HMOs such as complaint rates, disenrollment rates, rates of outcomes and appeals as well as the results of its investigations or any findings of noncompliance by HMOs.

C. Check the effectiveness of a plan's quality assurance and utilization management processes and, using trained clinical evaluators, include in that examination a systematic consideration of any PRO findings concerning the quality of the plan.

MCOs also have written procedures for taking appropriate remedial action whenever ...inappropriate or substandard services have been provided....

D. Impose an appropriate level of sanctions when a significant quality deficiency is detected—until such deficiencies are rectified—such as freezing enrollment in the plan by stopping payment for new Medicare enrollees. (See detailed discussion of sanctions under ASIM's recommendations for adequate enforcement.)

E. Provide for private sector accreditation as an alternative to federal review and certification of MCOs, provided that a deemed accrediting body's standards are equal to or stronger than the standards outlined for MCOs by HCFA.

F. Provide for external monitoring—by an independent, publicly-accountable group—of the effectiveness of the MCO's internal quality improvement processes, emphasizing collaborative efforts to improve quality rather than micromanagement.

Explanation: The GAO report issued last August on the degree of quality oversight the federal government conducts over MCOs found serious gaps in the level of attention HCFA gives to health plan deficiencies. Although HCFA may check to see if a health plan has quality management processes in place, there is little comprehensive effort made by HCFA to ensure that those processes are effective in maintaining quality of care. GAO also discovered that PRO findings of poor quality or questionable practices on the part of a health plan often are not shared or acknowledged when HCFA evaluates a health plan. As a result, HCFA has approved contract renewals with health plans that have been cited by PROs for failure to comply with certain quality standards.

Following the GAO report, PPRC and the Prospective Payment Advisory Commission issued a report in October 1995 urging the creation of a process to monitor trends in access over time, and identify access problems at various levels of a managed care system. Data for such a monitoring process would include enrollment and disenrollment patterns, including rates of early disenrollment. Such data would have to be compared to FFS claims data for time periods following disenrollment to determine if a patient's anticipated needs for services led to the enrollment patterns. Other useful data include beneficiary appeals to HCFA for reconsideration of plan coverage decisions.

The IOM recommends that all Medicare plans be "subjected to comparable state-of-the-art standards and monitoring for quality . . . When the standards and processes of private credentialing agencies meet or exceed those of the federal government, private organizations should be used to reduce duplication in the market.

As noted previously, in its 1996 report to Congress, the PPRC explicitly called for external monitoring of MCO's internal quality assurance methods:

> All health plans that serve Medicare beneficiaries should be subject to external quality review by an independent entity approved by the Department of Health and Human Services. Plans' internal quality assurance programs should be subject to periodic external review to verify that they meet established standards.

Assuring That Beneficiaries Have Access to a Fair, Objective and Timely Process for Seeking Reconsiderations and Appeals of Denials by MCOs for Medical Treatments, or for Having Other Grievances Addressed

I. Medicare MCOs should be required to meet the following appeals and grievance criteria:

A. As required under existing standards, the MCO should ensure that all enrollees receive written information about the appeals and grievance procedures at the time of enrollment. Given the findings by GAO and OIG that some MCOs have been violating this requirement without being sanctioned by HCFA, HCFA should strictly enforce this requirement and impose sanctions on plans that are not in compliance.

B. The MCO should review an adverse preauthorization determination—upon request of the enrollee, enrollee's family or enrollee's physician—within specified time frames that would allow for a rapid determination of denials for urgent and emergency care. HCFA's

The GAO Report ...found serious gaps in the level of attention HCFA gives to health plan deficiencies.

current standards do not include any specific requirements for timely review of emergency and urgent care. ASIM proposes the following time frames:

1. For urgent care services, within one hour after the time of the request for such review; and

2. For services other than emergency and urgent care, within 24 hours after the time of a request for such review.

C. The MCO should review an initial determination on payment of claims within 45 days after the date of a request for such review by the enrollee, enrollee's family or recipient of payment (provider), instead of the 60 days allowed under the existing standards.

D. The MCO should review a grievance regarding inadequate access to any physician specialist by an enrollee, the enrollee's family, or the enrollee's physician, within five business days. The current standards do not include any specific requirements on timely reviews of complaints concerning inadequate access.

E. The MCO should inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee and enrollee's physician of his/her right to reconsideration.

F. The MCO preauthorization/claims payment reviewer described in this section should be of the same or similar medical specialty as the provider of the service in question.

G. A request for a second reconsideration should be made in writing by the enrollee, enrollee's family or enrollee's physician and filed with the MCO or the Social Security Administration office within 60 days of the organization determination. The enrollee should request an extension if "good cause" is shown. The MCO should make a second reconsideration within 30 days, instead of the 60 days now allowed, and for access complaints, within five days. If the MCO does not reconsider in the beneficiaries favor, it should prepare a written explanation for all parties involved with the dispute and send the entire case to HCFA for a determination.

H. The MCO should be granted an extension from the above time requirements only if the appropriate providers have not forwarded them patient records for review.

I. If the MCO does not act within the prescribed time period, the case should be automatically decided in favor of the enrollee. Currently, beneficiaries are still subjected to the MCO's original denial of their request for payment of medical services, even when the MCO has failed to comply within the time frames for review in the existing standards.

II. When a case is turned over to HCFA (or its contractor) for a reconsidered determination, HCFA should:

A. As required under current regulations, notify the enrollee, the enrollee's family, the enrollee's physician and the MCO of:

1. The reasons for the reconsidered determination;

2. The enrollee and enrollee's physician's right to a hearing if the amount in controversy is $100 or more; and

3. The procedure that the enrollee or enrollee's physician must follow to obtain a hearing.

B. Make a reconsidered determination within 30 days for denials of covered services, as currently required, and within five days for access complaints.

C. As required under existing standards, inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee of his/her right to a hearing for reconsideration.

D. Establish that the reconsidered determination is final and binding unless a request for a hearing is filed within 60 days of the date of the notice of reconsidered determination by the enrollee, the enrollee's family or the enrollee's physician.

E. Decide the case in favor of the enrollee if HCFA or its contractor does not act within the prescribed time period.

III. Medicare should maintain its current standard requiring PROs to immediately review disputes between the MCO and the patient over the length of inpatient stays (stated below):

A. A Medicare enrollee, enrollee's family or enrollee's physician who disagrees with a determination made by the MCO that inpatient care is no longer necessary may request immediate PRO review of the determination.

B. The enrollee may stay in the hospital until the PRO makes a determination.

C. The PRO must make a determination and notify the enrollee, the enrollee's physician, the hospital and the MCO by the close of business the first working day after it receives the information from the parties involved necessary to make a determination.

IV. Any contractor used by HCFA to review appeals of an MCO's decision to deny payment for otherwise covered services and to review beneficiary grievances should be required to meet performance standards that are comparable to those required of Medicare Part B FFS carriers, including:

A. The contractor should be required to establish state or regional advisory committees of practicing physicians that reflect various medical specialties, practice settings and geographic areas. The advisory committees should:

1. Review the contractor's perfor-

mance on reviewing and adjudicating claims disputes;

2. Review newly proposed Medicare policies and policy changes as required by HCFA;

3. Address generic managed care problems raised by HCFA, the contractor, PROs, carriers, MCOs, physicians or beneficiaries. However, the committee will not involve itself with individual physician disputes with an MCO or the contractor;

4. Meet with the contractor on a quarterly basis; and

5. Make quarterly, formal reports to local and state medical associations and specialty societies.

B. The contractor should provide for timely notification and adequate opportunity for review by state medical societies and specialty societies of changes in criteria, protocols or other standards used by the contractor in making determinations about disputed claims.

C. The contractor should disclose to physicians and beneficiaries, upon request, all coding edits, medical necessity criteria, algorithms and practice guidelines used to review denials by MCOs.

Explanation: According to GAO, PPRC, and the IOM, the current appeals process acts too slowly. MCOs are given up to 60 days to make their initial determination. The internal MCO review process often can take up to six months to complete. Cases that require HCFA review can take even longer than six months—sometimes up to 270 days. Further, GAO found that MCOs and HCFA's own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

The IOM found that:

> The current Medicare appeals process has been shown to be slow and not adequately advertised by HCFA or health plans. Furthermore, the current appeals process is tailored more to reviewing whether a service should be reimbursed by Medicare or a health plan and less on the important issue of whether a needed service was denied. In a competitive environment, to attain better risk selection, health plans have the incentive to encourage healthier people to enroll in the plan and to discourage from enrollment those who need more services. This could prompt plans to be less responsive to the grievances of sicker Medicare enrollees.

To address these problems, the IOM "recommends that the existing appeals process by strengthened, streamlined, and better publicized."

ASIM recommends shortening the time delays involved in the appeals process and better oversight by HCFA to ensure that beneficiaries are not harmed when MCOs or HCFA's contractors fail to process appeals by the required deadlines. ASIM's recommendations would speed up the review process in the following ways: for all

Prompt review of urgent and emergency care would ensure that beneficiaries are not put in the position of having forgo such care—or risk incurring extensive out pocket costs.

requests (except for access complaints), the time frame for initial review would be reduced from 60 days to 45 days, and the time frame for reconsideration by the MCO would be cut in half, from 60 to 30 days. This could reduce the entire duration from initial determination to independent review of the determination by 45 days. For complaints about inadequate access, the duration of time from the initial complaint being filed to review by the independent contractor would be reduced to a maximum of 15 days. ASIM's recommendations for prompt review of urgent and emergency care would ensure that beneficiaries are not put in the position of having to forgo such care—or risk incurring extensive out-of-pocket costs—because of delays in getting authorization for such care.

The current regulations regarding immediate PRO review of inpatient stays are appropriate and should be maintained to protect beneficiaries from being discharged from the hospital prior to the time that their medical condition warrants.

HCFA or its contractor should establish regional committees of practicing physicians to advise them on Medicare policy changes and processing of claims disputes following the model established in Medicare FFS payment system, called Carrier Advisory Committees (CACs). HCFA or its contractor also must disclose the methods used to make coverage decisions. These standards are necessary to ensure that decisions made regarding coverage for Medicare beneficiaries are not made with "black box" technology. Medicare beneficiaries have the right to know why decisions regarding their medical care are made.

Assuring That Physician Incentive Payments Do Not Lead to Conflicts of Interest Between the Beneficiary and the Physician, Possibly Resulting in Inadequate Patient Care

HCFA should require:

A. MCOs that have financial incentive arrangements with physicians to provide adequate stop-loss coverage for physicians who are at substantial financial risk for services provided to Medicare and Medicaid enrollees. HCFA's interim final rule on physician incentive plans should be improved by:

   1. Reviewing the definition of "risk threshold." A 25 percent risk threshold may be too high for physicians in solo or small group practice. HCFA should consider developing a graduated risk threshold based upon the size of the physician group or based upon the number of patients in the physician's or physician group's patient panel. Using a graduated risk threshold that is lower on smaller patient panels—for example, 10 percent on a solo physician or patient panels of less than 100 patients—will provide greater protection for enrollees than a 25 percent risk threshold. For larger physician groups and larger patient panels, a 25 percent risk threshold is more appropriate.

HCFA or its contractor also must disclose the methods used to make coverage decisions.

2. Broadening the regulatory requirement for stop-loss coverage. The initial $10,000 stop-loss limit for patient panels less than 1,000 patients is too high to protect a solo practice or small group of physicians and their patients from unusually high medical expenses. Similarly, the higher stop-loss limits for patient panel sizes greater than 1,000 patients are too high to adequately protect physicians and their patients from random risk of unusually high medical expenses.

3. Increasing the 90 percent protection above the stop-loss limit to 100 percent; 90 percent stop-loss protection is not an adequate safeguard for patients.

B. MCOs to comply with the final rule without any further delay, instead of postponing implementation until 1997.

C. MCOs that pay physicians on an individual or group capitation basis to adjust their provider capitation payments to reflect the risk selection of the patients assigned to an individual participating provider, using risk adjustment methodologies as approved by the Secretary for this purpose.

Stop-loss limits do not protect against systematic risk caused by having a sicker-than-average patient pool.

Explanation: Many Medicare MCOs have financial arrangements with physicians that can result in the physician being rewarded if he or she provides fewer services to beneficiaries. This can create a potential conflict of interest between the physicians' financial interest in providing fewer services and the beneficiary's interest in knowing that the physician will always provide all of the services that potentially can benefit the patient. Congress recognized this problem when it enacted legislation in 1990 that requires HCFA to develop rules governing physician incentive arrangements. In March 1996, HCFA published final rules on physician incentive arrangements. Unfortunately, HCFA decided to postpone implementation until 1997 so that the stop-loss requirements would go into effect on the same date as the annual renewals of MCO contracts. Although some press reports suggested that this decision was in response to industry pressure to weaken the consumer protections in the regulations, HCFA officials have indicated that they do not plan to make any substantive changes in the regulation's requirements.

ASIM believes that the rule needs to be strengthened, not weakened. Stop-loss limits only protect physicians and their patients against the random risk of patients who incur unusually high medical costs—not against systemic risk caused by having a sicker-than-average patient pool. This is a particularly troublesome issue for general internists and internal medicine subspecialists because internists generally treat patients with more complex and chronic disease conditions than other medical specialties. In ASIM's *Reinventing Managed Care* policy paper, titled "Assuring Appropriate Patient Care Under Capitation," we recommend that MCOs should modify the methods used to determine capitation payments to include several factors, in addition to age and gender, that can predict the use of medical care resources. There is a great potential for systemic risk adversely affecting patient care under capitation, and severity adjustments are needed regardless of the pool size of enrollees included under the capitation rate. Although stop-loss coverage generally protects beneficiaries and physicians from random risk, the

rule does not set the stop-loss threshold at a level low enough to adequately protect patients who are treated by solo practitioners and physicians in the small group setting.

Financial arrangements with physicians that could compromise care was one of the principal concerns of the IOM committee. The IOM report states:

> The committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional roles as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee favors the abolition of payment incentives or other practices that may motivate providers to evade their ethical responsibility to patients to provide complete information to their patients about their illness, treatment options, and plan coverages. So-called anticriticism clauses or gag rules should be prohibited as a condition of participation.

ASIM agrees with the IOM's view that gag clauses and other restrictions on written and oral communications to patients—including prohibitions on physicians' discussing with patients concerns about the impact of an MCO's financial arrangements, referral restrictions, or utilization review policies on the patients ability to access needed services—should be strictly prohibited. ASIM does not favor a complete ban on all arrangements that place physicians at financial risk; rather, we support regulating such arrangements—by requiring full disclosure to patients, by severity-adjusting capitation payments, and by providing stop-loss coverage—to minimize any potential conflict between the physician's and MCO's economic interests and the patient's interest in getting the best care possible.

Assuring That Medicare Payments to MCOs Do Not Create Incentives for MCOs To Discriminate Against Sicker Patients with More Complex—and Costly—Illnesses

The HHS Secretary should be required to:

A. Develop a methodology for adjusting Medicare and Medicaid capitation payments to MCOs to reflect risk selection, paying less to plans attracting favorable selection and more to plans with adverse selection. In developing the methodology, the Secretary shall consider factors such as prior utilization and current health status of beneficiaries.

B. Report to Congress on the proposed methodology no later than June 1998.

C. Unless Congress acts to block the proposed methodology, implement the severity adjustments no later than Jan. 1, 1999.

There are several methodologies that are more predictive of resource consumption than the current AAPCC methodology.

Explanation: In its 1995 and 1996 reports to Congress, PPRC has stated the importance of adjusting payments to Medicare MCOs to take into account the severity of illness of beneficiaries enrolled in the plans. The current adjusted-aver-

age per capita cost (AAPCC) methodology adjusts payments based on age, sex and dual Medicare-Medicaid eligibility. Such adjustments do not accurately predict how much medical care will be needed by beneficiaries with more complex and severe—and typically more costly—illnesses. Consequently, plans that have a larger proportion of sicker patients are penalized, while those with healthier patients are rewarded. This acts as a strong incentive for plans to avoid enrolling sicker beneficiaries. Despite the recognition by PPRC and HCFA that better severity—or risk adjustment—methodologies are needed, there is concern that none of the current risk-selection methodologies that have been developed by health services researchers fully predict variations between patients in their future use of health care resources. ASIM believes, however, that there are several methodologies that are more predictive of resource consumption than the current AAPCC methodology. Such risk adjustment methodologies can be implemented even as HCFA continues its research into improved adjustors. ASIM's recommendations would assure that development of improved risk adjustors is not delayed because they are less than perfect.

HCFA should increase sanctions on MCOs based on the frequency of a problem.

Assuring That HCFA Adequately Enforces Current and Proposed Standards

A. HCFA should be more willing to exercise its existing statutory authority to impose sanctions uniformly against MCOs for contractual violations that can substantially impair beneficiaries access to quality medical care. HCFA should specifically use its existing authority to apply graduated levels of sanctions that would impose increasingly-higher levels of sanctions on repeat violators. The types of violations that should result in imposition of sanctions include:

1. Failure to provide medically necessary services required by a beneficiary;
2. Requiring enrollees to pay excess premiums;
3. Inappropriately expelling or excluding a beneficiary from participation;
4. Denying or discouraging enrollment;
5. Falsifying information;
6. Not promptly paying claims; and
7. Inappropriately terminating participating physicians.

Explanation: In 1988, 1991 and 1995, GAO reported that HCFA was not using its enforcement authority to impose sanctions or monetary penalties on MCOs that fail to meet federal standards. ASIM recommends that HCFA increase sanctions based on the frequency of a problem. Currently, Medicare MCOs can take years to correct their problems. GAO suggests that HCFA begin using its sanction authority to increase the rate of compliance on the part of Medicare MCOs.

Conclusion

ASIM challenges Congress, HCFA and the Medicare managed care industry to adopt the standards as proposed in this paper to protect beneficiaries who choose to enroll in MCOs. ASIM's recommendations are not "anti-managed care;" instead, they attempt to define a reasonable set of consumer protections that good managed care plans should have no difficulty in meeting, without undermining their ability to provide cost-effective medical care. Indeed, ASIM is a strong proponent of reforming Medicare to give beneficiaries a wider choice of health plans, including managed care plans and FFS approaches. Expanded choice also requires, however, greater accountability. MCOs must be held accountable for the quality of—and access to—care they provide to beneficiaries, just as the federal government holds FFS providers accountable for the quality, cost, and access to care they the provide.

The need for more disclosure, an improved appeals and grievance process, clearer guidelines on emergency care, improved protections against arbitrary denials of services and "deselection" of qualified physicians, more external oversight of MCOs' internal quality improvement processes, improved methods to adjust capitation payments by severity, and better enforcement of existing standards is well-supported in the research literature. Throughout this paper, ASIM has cited references from the Physician Payment Review Commission, General Accounting Office, Prospective Payment Assessment Commission, and the Institute of Medicine's Committee on Choice and Managed Care that support the general findings and recommendations in this paper, as well as many of the specific recommendations made by ASIM. Private sector accreditation standards, as well as several of the legislative and regulatory initiatives mentioned in this paper, also support the need for improved ways to hold Medicare MCOs accountable to the public.

It should no longer be debatable that more needs to be done to hold Medicare MCOs publicly accountable for their impact on quality and access. Although continued debate on specific approaches to improving accountability are likely, it is not acceptable for Congress, HCFA, or the managed care industry to ignore the need for improvements or to adopt a "go slow" approach to making improvements. ASIM's recommendations present a blueprint for needed reforms, and we challenge the managed care industry and policy makers to join with us in bringing about the improvements outlined in this document.

These recommendations attempt to define a reasonable set consumer protections that good managed care plans should have no difficulty in meeting. . . .

Endnotes

1. The Clinton administration's FY'97 Budget Proposal.

2. American Medical Peer Review Association. Testimony to the Ways and Means Committee, March 21, 1995.

3. Conference Agreement, Balanced Budget Act of 1995.

4. Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA), Office of Inspector General (OIG). *Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Health Care Organizations,* Final Rule with Comment Period. Washington, DC, March 27, 1996.

5. HHS. "HCFA Announces 25 Managed Care Plans As Candidates to Participate in Medicare Choices Demonstration Project," *HHS News*, April 15, 1996.

6. General Accounting Office (GAO). "Medicare: Increased HMO Oversight Could Improve Quality and Access to Care." *Letter Report to the Special Committee on Aging*. Washington, DC, Aug. 3, 1995 (GAO/HEHS-95-155).

7. GAO. "Medicare: Federal Efforts to Enhance Quality of Care." *Report to the Chair, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives*. Washington, DC, April 10, 1996 (GAO/HEHS-96-20).

8. GAO. "Medicare HMOs: Growth Concentrated in Selected States." *Letter Report to the Hon. John Kerry, U.S. Senate*. Washington, DC, Jan. 18, 1996 (GAO/HEHS-96-63).

9. H.R.2400, The Family Health Care and Fairness Act of 1995.

10. HCFA, Medicare Program. *Criteria and Standards for Evaluating Intermediary and Carrier Performance During FY'95*, General Notice with Comment Period. Sept. 7, 1994.

11. HCFA. *Qualifying Contracts for Medicare Contracts*, 50 CFR, 417.400-417.694.

12. Institute of Medicine. *Improving the Medicare Market: Adding Choice and Protections.* July, 1996.

13. OIG, HHS. *Beneficiary Perspectives of Medicare Risk HMOs*. March 1995.

14. Physician Payment Review Commission (PPRC) and Prospective Payment Assessment Commission. *Joint Report to the Congress on Medicare Managed Care*. 1995.

15. PPRC. *Annual Report to Congress*. 1995, 1996.

16. Utilization Review Accreditation Commission. Current standards 4.0-5.2; *1995 Draft Standards*, 1.0 - 11.0, 13.0 - 20.3, 67.0 - 79.4.

ASIM

REINVENTING MANAGED CARE

Assuring Appropriate Access to Laboratory Testing For Patients in Managed Health Care Plans

Recommendations of the American Society of Internal Medicine

September 1996

Assuring Appropriate Access to Laboratory Testing For Patients in Managed Health Care Plans

Contents

Executive Summary

Managed care organizations (MCOs) are becoming the dominant health insurers in many areas throughout the country. Health plans increasingly are insisting that physicians send all of their laboratory specimens—and often their patients—to a reference laboratory for testing, even though the tests could be performed in the physician's office laboratory (POL). Many plans have either refused to reimburse physicians for work performed in their own laboratories or have reduced reimbursement far below the level necessary to operate a POL, so physicians must send their patients to outside laboratories. If this trend among MCOs continues, the American Society of Internal Medicine fears that patients could lose access to convenient in-office laboratory testing. This policy paper argues for maintaining the use of POLs, and offers recommendations to physicians negotiating with MCOs.

If this trend among MCOs continues... patients could lose access to convenient office laboratory testing.

In response to concern from our membership, ASIM surveyed MCOs in early 1995 to determine how many plans were denying physicians full access to their in-office laboratories and why this was occurring. This paper includes the results of that survey and addresses the reasons MCOs gave on why they deny full access to POLs.

This paper is Part VI of ASIM's Reinventing Managed Care series, which includes: *Reinventing Medicare Managed Care; The Use of Board Certification to Credential Internists; Patient Access to Internist-Subspecialists in Gatekeeper Health Plans; Assessing Physician Performance in Managed Care*; and *Assuring Appropriate Patient Care Under Capitation*. Copies of these papers are available from ASIM upon request.

Assuring Appropriate Access to Laboratory Testing For Patients in Managed Health Care Plans

Introduction

Some MCOs impose tight cost control mechanisms on physicians that can threaten the physician-patient relationship. The shift to managed care has affected physician-patient relationships by restricting a patient's choice of a laboratory testing location, decreasing the physician's time available for counseling, and imposing reimbursement incentives that reward physicians for ordering fewer tests.

Physicians are closing their laboratories because of managed care. A recent study indicated that reimbursement by third-party payers and being required to use reference labs were two of the top three reasons why physicians reduce or eliminate testing in their labs. The cost of complying with the Clinical Laboratories Improvement Act (CLIA) regulations was the third reason.[1] MCOs increasingly are offering large reference laboratories exclusive contracting on a capitated basis—paying the labs a set amount per enrollee per year to cover all of the laboratory testing done for its enrollees. As a result, MCOs typically exclude—or severely restrict—physicians from testing in their own offices.

If this trend continues, managed care could make physicians' office labs obsolete. POLs are successful today because they have a sufficient volume of work to remain open. If POLs had to reduce their testing to only Medicare and fee-for-service patients, it would no longer be cost-effective for them to continue operating. Patients would lose the advantages of being able to get lab tests done in their doctor's office.

Although few physicians have tried to negotiate an extended laboratory menu with MCOs, some of those who have are finding their efforts successful. Managed care plans traditionally have designated one large reference or hospital laboratory as their single, centralized laboratory services' provider. However, many plans are discovering that sole-source laboratories may have trouble adequately meeting the service needs of large or hard-to-access geographic areas. Additionally, many plans have realized that POLs can perform testing at the same or less cost, with the same or better quality and greater convenience to the patient than reference laboratories. Consequently, these plans are willing to offer contracting physicians the opportunity to continue their in-office testing.

Many plans have realized that POLs can perform testing at the same or less cost, with the same or better quality.

A good example of an MCO that permits physicians to use their own facilities while containing costs and maintaining quality is The George Washington University Health Plan. It offers consultation services for physicians operating office laboratories, including working directly with the laboratory staff to offer advice on meeting both CLIA and Occupational Safety and Health Administration requirements. In exchange, all POLs are required to send copies of their CLIA certificates and quality assurance plans to the health plan. The plan provides continuing education seminars, newsletters for participating physicians, and physician relations phone lines, exemplifying the working relationship ASIM believes should exist between POLs and managed care plans.

The Current Picture

Nationwide, heath maintenance organization (HMO) penetration was up to 21.1 percent in 1994.[2] Approximately, 60 percent of these plans required physicians to send their lab work out—even if they had in-office testing capability.[3] As HMOs and other managed care plans continue to increase their presence in the health care market, their influence over laboratory testing also will increase.

In 1995, ASIM surveyed managed care plans to determine how much they influence physician practices. The survey included 62 predominately network-model HMOs (but no preferred provider organizations). Survey respondents included most of the major national insurance companies that own HMOs, as well as many regionally focused HMOs. The following summary of results reveals managed care's current trend away from in-office laboratory testing.

Many patients clearly want to be able to have laboratory tests done in their doctor's office.

Does your organization require physicians to send all or some laboratory specimens to independent labs?

Yes	60%
No	40%

Why does your organization require physicians to send laboratory specimens to independent labs?

Because the plan has negotiated an exclusive, discounted rate with one or more commercial labs	31.8%
Because independent labs are more cost-effective.	27.1%
Because of concerns about the quality of lab work performed in physician offices.	23.3%
To control utilization of lab work being performed.	15.0%
Because employers and patients prefer that independent labs perform lab work.	2.8%

Does your organization allow the physician to decide which independent lab to use, or must the physician use the lab that your organization has chosen?

Physician's choice	5.4%
Plan's choice	94.6%

If your organization requires physicians to send some or all lab work to an independent lab, do you reimburse physicians for specimen handling?

Yes	57.9%
No	42.1%

What Are the Benefits to Patients of Physician Office Laboratory Testing?

Many observers are concerned that patient care would suffer without POLs. Today, patients benefit from—and want to maintain access to—in-office testing. In-office testing offers patients greater convenience and more timely results—at less cost and at a level of quality that is equal to, or greater than that offered by commercial labs.

1. Patients Want Access to In-Office Testing.

Many patients clearly want to be able to have laboratory tests done in their doctor's office. Consumers are responding to the increased competition among managed care companies by showing less loyalty to any particular MCO and more interest in extra benefits. As competition among MCOs increases, patient satisfaction will become a more important factor in retaining members. A recent study surveyed consumer satisfaction with their health care plans.[4] When asked what they liked about their health plans, consumers indicated that they considered the availability of laboratory services in the office "moderately important." However, 90 percent of those surveyed indicated that they would prefer to have blood drawn by a nurse or a physician in their physician's office rather than going to a hospital or other reference lab for testing.[5] Many of today's health consumers know that in-office testing is possible and could express dissatisfaction with—i.e., leave—plans that do not offer this valued service.

2. In-Office Testing Is Convenient and Provides Timely Results.

Patients value their personal physician having the capability to provide a full range of services in one location. The opportunity to have their specimens drawn and analyzed, and the results reported during one visit, is a service many patients have come to rely on, particularly in urgent medical situations. This often allows physicians and patients the opportunity to discuss the test results while the patient is still in the office. Additionally, it allows the physician to prescribe medications to begin treatment sooner.

Offering patients quick and accurate test results is a component of in-office testing that patients have come to rely upon. One survey found that 79 percent of patients believed it was important to have their laboratory results before leaving the office, (57 percent of these patients were enrolled in an MCO).[6] Continuing to offer patients timely test results will increase patient satisfaction and the quality of health care significantly. Unfortunately, a patient sometimes must wait up to four days to receive test results from outside reference laboratories. This delay inconveniences and may potentially harm patients.

Some studies report the time personnel save with in-office testing is up to 14 minutes per patient.

Sending patients to outside laboratories for specimen drawing can be cumbersome. For many patients, squeezing a doctor's appointment into their busy schedules is a challenge, and to get care during the typical physician's office hours, employees must take time off work. The amount of time they will miss from work will increase substantially if they have to go to a second site for specimen drawing. The increased travel time and expense of getting to a reference lab costs the patient, as well as the

patient's employer, since the patient may miss more time from work.

Additionally, many elderly, disabled and underprivileged individuals are unable to get to a reference laboratory. Lack of transportation can stand in the way of a patient receiving necessary laboratory testing. Unfortunately, these people also are often the most seriously ill patients. As the trend to include more Medicare and Medicaid patients in managed care continues, this problem will be magnified. To deny the elderly and underprivileged convenient access to quality care is to impose unnecessary and costly hardships.

3. POLs Offer Quality Testing and Improved Efficiency.

Physicians and their staff prefer to use in-office laboratories because they enhance the quality of patient care. Often, in-office test results can be incorporated into the patient record the same day the testing is ordered and performed, thereby avoiding multiple filing and retrieving of the patient's chart, as well as follow-up phone calls to the patient and pharmacy to report the results. In some circumstances, in-office testing saves time for the patient, physician and physician's office staff by eliminating the need to see a patient a second time to report test results and discuss follow-up therapeutic options. Some studies report the time personnel save with in-office testing is up to 14 minutes per patient.[7] Additionally, insurance carriers that now process two claims for a beneficiary when laboratory tests are performed by an outside reference laboratory could save time by having to process only one claim for the physician service and the in-office laboratory tests.

Timeliness of the receipt of lab results...is directly connected to the quality of care.

Although managing the cost of health care is a valid concern, the quality of care for the patient is of greater importance than administrative convenience or cost cutting. Patients prefer to have their laboratory testing done in their physician's office lab because they are assured that the quality and accuracy of testing is under their doctor's control.

When an MCO forces a physician to refer to a reference laboratory, the physician no longer can ensure that the patient will follow through with the physicians's orders and obtain the necessary testing after the patient leaves the office. Physicians cannot guarantee that their patients will receive the test results from the reference lab in a timely manner. Furthermore, all reference laboratories use different reporting forms, so it is more difficult for the referring physician to locate the appropriate information on the form.

Timeliness of the receipt and transmission of lab results goes beyond convenience; it is directly connected to the quality of care. All internists encounter patients with problems that require near-immediate ("stat") lab information for appropriate clinical decision-making. Examples may include patients with suspected bleeding and anemia who require immediate blood counts, patients with severe sore throat and fever for whom an appropriate antibiotic choice depends on rapid strep screening, and severely ill patients with diabetes, whose management depends on rapid determinations of blood sugar and other chemistry tests. In circumstances such as these, the ability of the physician to have lab testing immediately available in the office is critical to the quality of the care provided for the patient.

Some opponents of in-office testing will argue that quality traditionally has suffered in the POL environment. Although

there are some old studies—all controversial—that suggest that the quality of testing is better in reference laboratories than in physician office laboratories, there are an equal number of studies that show this is not true.[8] Physician office laboratories ensure the utmost quality by regularly performing proficiency testing and participating in laboratory accreditation programs, such as the Commission on Laboratory Accreditation (COLA). Even though there is little evidence to suggest that stringent regulations are needed to assure the reliability of testing in POLs, physician-owned labs must meet CLIA and/or state laboratory quality standards like reference and hospital laboratories.

4. POL Testing Can Cost Less Than Reference Laboratories.

A recent survey identifies many situations that demonstrate testing performed in a POL is less expensive than testing performed in a reference lab. A detailed study of 100 physician laboratories indicates that POL costs—especially in group practices—are much lower than might be expected, and often are less than in many hospital and reference laboratories.[9] This study compared the relative economics, test-ordering patterns, and patient perceptions related to point-of-care testing in the physician office. The study compared total direct and indirect costs and operational characteristics of physician laboratories employing a wide range of

Chart A **Cost Per Laboratory Test in Medical Group Practices[10]**

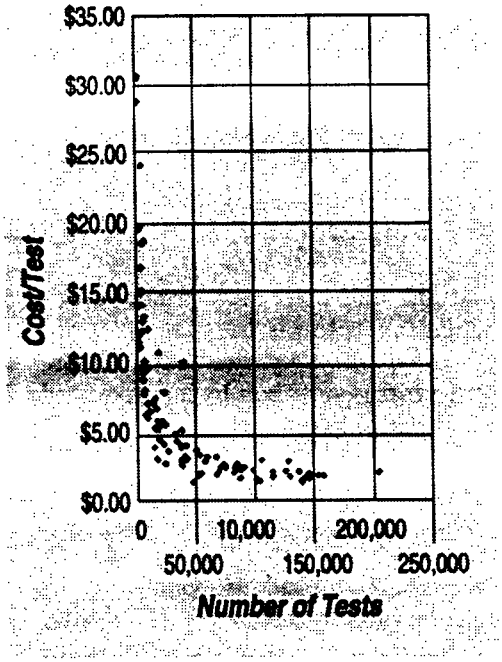

Table A **Comparison of Laboratory Testing Costs in Community Hospitals and Medical Group Practices[11]**

	Total Tests (annual)	Cost per test
Community Hospital A	319,172	$4.59
Community Hospital B	266,469	$3.28
Community Hospital C	670,515	$4.61
Medical Group #8 (10 physicians)	110,399	$2.85
Medical Group #69 (23 physicians)	92,444	$2.17
Medical Group #17 (59 physicians)	656,674	$1.34

Physician-owned labs must meet CLIA and/or state laboratory quality standards....

laboratory facilities to develop an indication of the true costs for facilities performing both minimal and comprehensive in-office testing. These results show that in many testing situations, POLs are more cost-effective for MCOs than outside reference laboratories.

The most persuasive statistics from this study involve physician practices performing more than 50,000 tests per year. As Chart A (page 9) demonstrates, the average cost per test in these higher volume laboratories is approximately $2.50—some drop to $1.25 per test. The study also shows that savings continue to increase as the volume of testing increases.

Many group-practice laboratories actually operate at a lower cost than hospital laboratories.

Furthermore, the study shows that a comparison of the cost of testing done in group-practice POLs and in outside reference laboratories is, at a minimum, competitive. Many group-practice laboratories actually operate at a lower cost than hospital laboratories. As Table A (page 9) demonstrates, when physician medical group practices are compared to community hospitals with similar test volumes, the average cost per test ranges from $1.34 to $2.85 for the POL, and $3.28 to $4.61 for hospitals. Recent improvements in laboratory equipment have enabled physicians to perform many tests cheaply with ease and accuracy. For example, the reduction in equipment prices for certain tests now means that a physician can justify the cost of the equipment without performing a high volume of tests on it. As technology continues to improve, it will become increasingly easier and cheaper for physicians to perform tests themselves.

Several physician laboratories in the study had lower costs than outside reference laboratories. Large regional and national reference laboratories are assumed to operate at a minimum cost of $1.50 to $1.75 per test based on the high fixed capital and operating costs attributed to their sophisticated courier, information and customer service networks.[12] Clearly, many group practices (as shown by the chart on page 9) can offer further reduced prices. Additionally, two practices in the study that are paid almost exclusively by MCOs have average costs per procedure that are significantly lower—about one-third the cost—than reference laboratories.

A detailed comparison of testing prices between POLs and outside reference labs in Broward County, Fla., found outside reference labs billing 50-200 percent

Table B **Laboratory Fees for Tests Commonly Performed in POLs and Reference Labs—Broward County, Fla.**

	Average POL Price	Average Reference Lab Price
SMAC 25	$35	$60.50
CBC	$15	$29.50
Cholesterol	$30	$68.50
FSH	$40	$110
PSA	$30	$95

higher than POLs. In late 1992, the Florida Society of Internal Medicine, the Florida Medical Society, the Florida Academy of Family Physicians and the Florida Society of Pathologists compared the fees charged by outside reference labs to those charged by physicians with in-office laboratories. The price disparity between the two is alarming. Table B (page 10) shows price discrepancies among commonly performed tests in each setting.[13]

There are many hidden costs that are difficult to measure, but which obviously exist in laboratory testing. For example, when patients trust their physician, they are more likely to comply with the recommended treatment instead of letting the problem escalate. This prevents a dramatic increase in the cost of care. Patients have a greater trust in results from tests performed by their physician-office lab than in those performed by outside reference laboratories. Another cost-savings that is difficult to estimate is the amount spent on unneeded care. If in-office testing is not available and tests must be ordered through a reference lab, physicians may have to prescribe medications or send their patients to the emergency room for immediate testing. Eliminating this waste will save patients and their insurers money. Finally, employers save money when employees spend more time at work and less time waiting in a laboratory for testing.

In addition, when testing is provided in a POL, the patient and the patient's insurer can be assured that the POL performed and billed only the tests the physician ordered. Commercial reference labs have been known to provide—and bill for—tests that were not ordered by the physician. The federal government has imposed several multimillion-dollar fines in recent years on commercial reference labs billing for tests that were not ordered.[14]

ASIM does not believe all testing should be shifted to reference laboratories to reduce the costs associated with laboratory testing. Cost-effectiveness is a balance between reducing delivery costs and improving the patient's health. To achieve this, ASIM encourages MCOs to work with physicians to implement cost-effective intervention strategies that take advantage of POL options while keeping patients' health in mind at all times.

Patients have a greater trust in results from tests performed by their physician office lab. . . .

Recommendations to Physicians

Negotiating with Health Plans To Maintain Use of In-Office Laboratories

To remain competitive, MCOs must differentiate themselves in new ways. One way to do this is to negotiate comprehensive laboratory testing panels with their physicians.[15] Health care consultant, Sheila Dunn, DA, MT, says that the main reason physicians are not allowed to perform tests in their offices is because they don't ask if they can. Her experience shows that fewer than 10 percent of physicians bother negotiating any part of their managed care contracts. However, the good news is that 90 percent of those who negotiate to maintain a full menu of laboratory services receive some concessions.[16]

The following recommendations will be useful to physicians negotiating laboratory contracts with managed care plans:[17]

1. Thoroughly prepare for the meeting. It will be helpful for you to identify—and perhaps even rank—the tests that you think are most important to your patients and therefore need to continue to be performed in-office. Find out which of these tests—if any—the plan already intends to permit. Prepare reasons why each of the other tests on your list should be included in the contract. You may find it useful to compare this list with the list that other plans are offering you or your colleagues. Additionally, it is important to know which provisions you are prepared to argue heavily for and which you are willing to concede. If you do not feel confident negotiating on your own, hire a professional negotiator who can present your case to the MCO. There are many experienced lawyers and practice consultants who understand managed care contracts and can negotiate for you successfully.

2. All physicians in the meeting should agree. If you are part of a group practice, it is important that the health plan recognizes that all members of your practice are in favor of the expanded list. When explaining the significance of each test, you want to make sure that each physician agrees.

3. Explain the patient benefits. Using the explanations provided in this paper, convince the health plan of the benefits of your in-office laboratory: the ability to provide timely, convenient, quality and cost-effective patient care. It may even be helpful to give examples of —or testimonials by—patients who would be inconvenienced and whose care could be compromised by reference laboratory testing.

4. Put the agreement in writing. Once you have negotiated an acceptable agreement with the managed care plan, immediately put it in writing and have the plan's representative sign it. This will ensure your right to test in your office should the plan decide later not to follow through on the arrangement.

5. Prepare for later re-negotiations. If you do not receive permission to do all the testing that you asked for during the negotiations but you still want to work with the plan, you should continue to develop your reasoning for providing the omitted tests. There will be opportunities to re-negotiate your contract with the plan. At that time, you should describe

the extent of patient inconvenience that resulted from omitting the tests, as well as any advanced developments in automation since the last meeting. During this time, it also is appropriate to encourage patients who complain about the inconvenience of outside laboratories to communicate their dissent to the health plan and their employer. Since automation in laboratory technology is changing rapidly—offering faster, more accurate and cheaper testing—it is possible that a plan's reasons for denying the inclusion of a certain test two years ago are no longer applicable.[18] During your negotiations, clearly explain how a newer generation of compact, portable or transportable instruments have led to relative ease of operation and robust performance in the hands of experienced personnel.

Recommendations to MCOs

Patient Access to Physician Office Laboratories

1. MCOs should reach agreement with their participating physicians on the types of laboratory tests that should be routinely made available in the physician's office—based on the specialty of the physician running the lab—so the appropriate tests that contribute to prompt diagnoses are available to the patient.

2. MCOs should not require patients to travel to a reference lab to get their tests done. Physicians should be reimbursed an adequate fee for the in-office drawing and handling of tests that are sent to a reference lab for testing.

3. MCOs should survey enrollees on their satisfaction with access to laboratory services and make changes in their laboratory arrangements—such as expanding access to POLs—if such surveys support a conclusion that patients prefer to have their tests done in their doctor's office.

4. MCOs should be willing to negotiate with individual doctors and medical group practices to expand the menu of laboratory tests that may be provided in the physician's individual POL beyond the minimum testing set necessary.

5. MCOs should compare the costs of tests sent to outside reference labs to POLs and allow POLs to provide laboratory tests at a competitive rate.

6. MCOs should address concerns about potential over-utilization of laboratory tests in POLs by using severity-adjusted and specialty-specific profiling, or by negotiating arrangements that include placing physicians at financial risk for lab tests, rather than prohibiting physicians from providing in-office tests.

7. To address quality concerns, MCOs should consider requiring all labs—POLs and reference labs—to participate in proficiency testing and to obtain accreditation from COLA or other accrediting organizations.

Conclusion

MCOs should permit patients to choose convenient, timely and quality testing in physician office laboratories, and should sufficiently reimburse physicians for the cost of providing these services. To compete in this changing health care environment and to retain consumer loyalty, MCOs must meet the demands of their consumers. Quality and convenience should be as important as analyzing physician patterns of test ordering and clinical outcomes.

When MCOs expect physicians' staff to draw and handle lab specimens—but do not adequately compensate physicians for the handling of these tests—they place financial burdens on physicians. In the MCO survey ASIM conducted, the most common reimbursement rate for specimen handling was $5. However, many MCOs did not reimburse for specimen handling at all, and others included the service in their capitation rate. Adequate compensation for this service is necessary, especially for specimens that require extra attention. It is critical to consider the physicians' costs for handling and transporting specimens, needles and syringes.

This paper has shown that patient satisfaction and health plan loyalty will increase if patients are allowed access to in-office testing and that such testing is high-quality, efficient and cost-effective.

Patient satisfaction and health plan loyalty will increase if patients are allowed access to in-office testing....

Endnotes

1. Ambulatory Sentinel Practice Network/Internal Medicine Center to Advance Research & Education. Laboratory Medicine Questionnaire, 1996.

2. Marion Merrell Dow. *Managed Care Digest / HMO-PPO Edition*, 1995.

3. American Society of Internal Medicine (ASIM). "Managed Care HMO Survey Results," 1995, pp.13-14.

4. Root C. "Cost Versus Benefits of Point-of-Care Laboratory Testing in the Physician/Clinic Office." Barrington, Ill.: Venture Resources, 1995, p. 234.

5. *Ibid.*

6. *Ibid.*

7. Baer D. "The Benefits of In-Office Testing." Commission on Office Laboratory Accreditation *Update*, January/March 1996, p. 3.

8. Schectman J, Elinsky E, Pawlson G. "Self-Reported Versus Actual Test Ordering Behavior Among Primary Care Clinicians." *Quality Review Bulletin*, February 1992, p. 60.

9. Root C. *Op. cit.*

10. *Ibid.*

11. *Ibid.*

12. *Ibid.*

13. Florida Society of Internal Medicine. Survey, reported Nov. 6, 1992.

14. Weissman D. "National Intelligence Report," Vol. 17, No. 9, Feb. 27, 1996.

15. Seith A, Kanwal N. "Consultation Services for Physician Office Laboratories." The George Washington University Health Plan, Washington, D.C., 1993.

16. Dunn S. "How to Convince a Managed Care Plan to Reimburse In-Office Testing." *Family Practice Management*, January 1996, p. 45.

17. Dunn S. *Op. cit.*; also: Wieland, JB. *The Internist's Guide to Negotiating Managed Care Contracts & Capitation Rates*. Washington, D.C.: American Society of Internal Medicine, 1995.

18. Bachner P. "Alternate Site Testing." *Archives of Pathology Laboratory Medicine*, Vol. 119, October 1995, p. 881.

Q's & A's on Pear's *New York Times* Article on HHS and HMO Regulation

Q. ***Why is the Administration shelving its plan to limit rewards HMO doctors?***

A. We are not shelving any of our regulatory responsibilities over Medicare and Medicaid HMOs. The Administration remains absolutely committed to the implementation of the physician incentive regulation referenced in today's *New York Times* article.

When the Congress passed the authorizing statute for this regulation, it explicitly directed that compliance should be tied to the effective dates of the contracts between Medicare/Medicaid and the HMOs. (All Medicare contracts start January 1st.) The modification reported in today's *New York Times* simply conforms the regulation to the requirements in the authorizing statute.

Q. ***What does this regulation do?***

A. This regulation works to assure that physicians in HMOs under contract with Medicare and Medicaid do not have excessive financial incentives to withhold appropriate care. It has three major enforcement provisions, which all go into effect on January 1, 1997:

- Requires health plans to report to the Health Care Financing Administration (which administers Medicare and Medicaid) any financial arrangement where the physician has incentives to underutilize or inappropriately provide health care to patients.

- Requires plans to disclose to beneficiaries (at beneficiaries' request) a summary of the financial arrangement and a summary of a survey of customer satisfaction with the plan.

- Requires the plan to provide insurance to assure that beneficiaries are protected against any excessive financial incentives on physicians to withhold care.

DRAFT 6-18-96

Managed Care Statement

The President supports both private and public efforts to promote quality managed care and to protect against inappropriate denial of necessary services. In both the Medicare and Medicaid programs, President Clinton is committed to ensuring quality of care for all beneficiaries.

As plan choices and the number of managed care enrollees increase, the Administration will ensure that quality is preserved and improved through:

- The Health Care Finance Administration's (HCFA) Quality Assurance Reform Initiative, a collaborative effort by HCFA, the states, the managed care industry, and consumer advocates to monitor and improve Medicare managed care.
- The HHS Interagency Forum which focuses on assuring managed care quality through the Medicare and Medicaid HEDIS program, and initiatives adapting successful private sector HMO performance benchmarks for use with Medicare.
- Research support of activities in the private sector to improve quality in managed care plans.

The President supports both private and public efforts to promote quality managed care and to protect against inappropriate denial of health care services. In both the Medicare and Medicaid programs, President Clinton is committed to ensuring quality of care for all beneficiaries. At the same time, the President recognizes that quality managed care is a cost-effective way to deliver health care.

As the number of people in managed care in both the private and public system increase, the Administration is working to ensure that quality is preserved and improved. An unprecedented number of Medicare beneficiaries have freely chosen managed care in recent years. The Health Care Financing Administration leads a collaborative effort among HCFA, states, the managed care industry and consumer advocates to monitor and improve Medicare managed care. In addition, as the number of Medicaid beneficiaries in managed care grows, the Administration is providing states, managed care plans, health care professionals, and consumers with information needed to ensure high quality. Finally, the Administration supports research into private sector efforts to improve quality in managed care plans.

DRAFT

STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

Committee on Ways and Means
Subcommittee on Health

U.S. House of Representatives

July 12, 1996

INTRODUCTION

Good morning. I am pleased to be back to testify before this subcommittee. As was the case last time I appeared before you, my subject today involves demonstration projects of the Health Care Financing Administration (HCFA). Last time, the subject was long-term care. Today, my testimony will focus on two projects -- the Medicare Choices demonstration and the Competitive Pricing demonstration -- central to our agenda of expanding managed care choices available to Medicare beneficiaries while improving our payment methodologies.

BACKGROUND

Over the past three decades, HCFA's use of its demonstration authorities has had a profound impact on the evolution and success of the Medicare and Medicaid programs. Through support, development and testing of innovations in payment, delivery, access and quality, HCFA has contributed significantly to major program reforms and improvements. Let me just mention a few examples.

As the result of a program of research and demonstrations begun in 1976, Medicare moved in 1983 from cost-based reimbursement for hospital care to a prospectively determined per case payment based on diagnosis. The prospective payment system saves billions of Medicare dollars annually while the Diagnostic Related Group (DRG) classification system on which it is based is used today by half of the State Medicaid programs, CHAMPUS, and many private insurers, managed care plans, and other countries.

When the hospice movement was still in its infancy, HCFA initiated a Medicare and Medicaid demonstration to determine whether hospice could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1994, about 270,000 Medicare beneficiaries used hospice care.

Beginning in the mid-1970s, HCFA sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional long-term care. These demonstrations served as the framework for the legislation authorizing the Medicaid waiver program under Section 1915(c) of the Social Security Act, under which home and community-based services may be covered.

HCFA's managed care programs were also rooted in extensive demonstration efforts. Beginning in 1980, HCFA tested the use of capitation payments for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis made sense for both beneficiaries and the program. Since HCFA implemented the Medicare managed care program in 1985, both the number of

beneficiaries enrolling in risk plans and number of risk plans contracting with Medicare have increased steadily. In 1985, only 309,000 beneficiaries were enrolled in risk plans whereas today over 3.6 million are enrolled in these plans, an increase of over ten-fold. Similarly, in 1985, only 32 risk plans contracted with Medicare. Today, 218 risk plans contract with Medicare.

There is general consensus among this Administration, the Congress, managed care plans, beneficiary advocates, and other providers that the Medicare managed care program should keep pace with private sector innovations while still ensuring that beneficiaries receive high quality care. For our purposes today, let me cite three areas that receive frequent mention. First, many believe that the types of managed care choices available to beneficiaries should be expanded to provide as many options as the commercial sector does. Within our current statutory authority, HCFA has recently expanded beneficiaries' managed care options to include a point-of-service option HMO. However, making additional choices such as provider sponsored organizations (PSOs) or preferred provider organizations (PPOs) widely available to Medicare beneficiaries is not possible under current law. Both the Administration and the Congress' balanced budget proposals include provisions which would allow Medicare to contract with these managed care organizations on a permanent basis.

Second, there is agreement that beneficiaries need reliable, comparative information on the managed care plans available in their local market areas in order to make informed decisions regarding enrollment. Again, there is common ground in the Administration and Congressional proposals. Both plans would require the Secretary of Health and Human Services to disseminate comparative information on managed care options at initial Medicare eligibility and during annual open enrollment periods. The Administration's bill also requires that information on Medigap plans be included in the comparative materials.

And third, most observers believe that the current payment methodology for managed care plans is flawed and should be improved. Under current law, the payment methodology is based on the Adjusted Average Per Capita Cost (AAPCC), generally referred to as "the AAPCC". Under the AAPCC methodology, payment levels for HMOs are derived from the utilization and cost experience in Medicare's fee-for-service population. There is general agreement that Medicare's payments to managed care plans should be "delinked" from fee-for-service costs in particular localities. In addition, recent research by HCFA confirms previous research findings that, because the current payment methodology does not adequately take into account the better health status of beneficiaries enrolled in Medicare HMOs, the Medicare program pays more for these beneficiaries than it would if they had remained in fee-for-service Medicare.

Congress has given HCFA broad demonstration authority to test potential improvements with which to address concerns like these. My testimony today will focus on two such demonstrations, Medicare Choices and the Competitive Pricing demonstration.

MEDICARE CHOICES

The purpose of Medicare Choices is to test the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and to evaluate the suitability of these options for the Medicare program. Our goal is to provide beneficiaries with additional delivery system choices and to increase options available to beneficiaries in rural areas. In addition, the Medicare Choices demonstration will help to develop approaches to a wide range of implementation issues--including payment methods, certification requirements and quality monitoring systems--which would be associated with some of the new Medicare managed care choices piloted in this demonstration. In developing the design specifications for Medicare Choices, HCFA and its contractor consulted extensively with interested parties including managed care plans.

In order to minimize unnecessary investment of resources by applicants, HCFA used a two-step application process to select the managed care plans participating in the Medicare Choices demonstration. HCFA first asked plans to submit a pre-application statement of interest and a brief project description. After reviewing the pre-applications, HCFA then requested selected organizations to submit more detailed proposals.

During the pre-application process, HCFA encouraged a broad range of managed care organizations, including PPOs, PSOs and HMOs, to submit innovative managed care proposals, such as point-of-service and primary care case management systems. We also encouraged applicants to propose alternative payment methodologies such as risk corridors and blended capitation payments and to indicate a willingness to test risk adjustment methods.

HCFA targeted nine cities as well as rural areas. The nine target cities were Hartford, CT; Sacramento, CA; Jacksonville, FL; Atlanta, GA; New Orleans, LA; Columbus, OH, Philadelphia, PA; Louisville, KY; and Houston, TX. These sites represent areas with high managed care penetration in the commercial sector but low Medicare HMO penetration. We also accepted innovative pre-applications from interested organizations outside these target areas. We received 372 pre-applications, representing nearly every State in the nation.

From these 372 pre-applications, HCFA selected 52 managed care plans for further consideration; we requested these plans to submit final applications to HCFA by December 15, 1995. Plans invited to submit final applications offered a wide range of managed care delivery models and proposed a variety of payment methodologies.

We selected "award candidates" based on geographic factors, innovation of design, and ability to meet eligibility requirements. We selected 25 award candidates for final consideration -- nine PSOs, eight provider-owned HMOs or providers with HMO partners, eight HMOs or other managed care organizations.

The 25 award candidates submitted a variety of payment proposals -- thirteen requested 95% of the AAPCC, five requested risk corridors around the AAPCC, seven requested other payment models such as partial capitation, blended payments, or capped fee-for-service payments. Sixteen of the 25 indicated an interest in testing a risk adjustment method. Five of the 25 award candidates are located in rural areas.

Award candidates are currently in the final steps of the Medicare Choices demonstration award process, which includes negotiations regarding payment methodology. Once these remaining details are worked out, HCFA will review plans to determine whether they meet standards regarding access, beneficiary protections, financial solvency, and quality assurance. While generally expecting plans to meet current law standards for Medicare HMOs, HCFA will evaluate plans participating in the Medicare Choices demonstration on a case-by-case basis.

HCFA expects all the plans to be certified and ready to enroll beneficiaries by January 1, 1997, but some may be ready to enroll beneficiaries sooner.

Both the Administration and the Congress support expanding Medicare managed care choices to include PPOs and PSOs and support similar provisions regarding PSO State licensing , solvency, and quality requirements. In the past, demonstrations have provided valuable information on implementing such program expansions. If HCFA is authorized in the future to contract with PPOs and PSOs on a permanent basis, the lessons learned from the Medicare Choices demonstration will significantly facilitate and accelerate implementation.

COMPETITIVE PRICING DEMONSTRATION

As I mentioned earlier, the current payment methodology for managed care plans is flawed and should be improved. For years, health care financing experts encouraged Medicare to move from our fee-for-service based method to one that relies more on a "market-based" payment rate. The managed care industry appeared to agree as well. The Group Health Association of America (now the American Association of Health Plans) testified before this Subcommittee in February 1995 that "payment rates are tied to the Medicare fee-for-service costs in a given area, and do not give the Medicare program the benefits of market dynamics present in the private sector." GHAA further stated that "Medicare payments to health plans should eventually be 'market-based'."

However, developing a market-based rate is a complex endeavor and the best methodologies are not immediately obvious. Recognizing both the need to seriously examine market-based rate setting and the intricacy of the task, about two years ago HCFA began to invest significant resources in developing a demonstration which we refer to as "competitive pricing."

HCFA conferred with many experts when designing the demonstration's bidding process, including consultants at Abt Associates, a firm with a long history in health care financing policy; academics recognized as authorities on competitive pricing at the University of Minnesota;

additional consultants with expertise in managed care; and other technical experts, including representatives of the managed care industry and the beneficiary population.

In developing the education and enrollment aspects of the demonstration, we worked with BENOVA (formerly knows as "Health Choice"), a contractor specializing in marketing and consumer education in the private and public sectors. We also convened two expert panels specifically to help develop the education and enrollment design specifications, one comprised of managed care plans and the other of beneficiary-oriented representatives. In addition, another contractor, Research Triangle Institute, conducted numerous focus groups in several states to determine beneficiaries' preferred methods of receiving information on health insurance options and their response to prototype educational materials. We also conducted 35 individual interviews with Medicare beneficiaries in four locations to more carefully examine their reactions to the prototype educational materials and to determine whether beneficiaries understood the most important elements included in these materials.

Components of the Demonstration

The competitive pricing demonstration focuses on two of the three concerns outlined in my introduction: altering the payment methodology for Medicare managed care plans and improving the ability of beneficiaries to make informed choices about their Medicare options. The demonstration has three essential and interrelated components: beneficiary education, third party enrollment and counseling, and market-based rate setting.

Beneficiary Education. HCFA will contract with an independent third party to prepare and distribute a comprehensive set of brochures to all Medicare beneficiaries in a specific market explaining the features of Medicare fee-for-service and managed care programs. The printed materials will highlight issues to consider when choosing between these two delivery systems. The materials will also include a chart comparing the benefit packages and premiums for all Medicare managed care plans in the beneficiaries' local market area in addition to comparisons of Medigap options. It will also include a list of HCFA-sponsored education seminars and informational videos and the number of a toll free counseling call center. The materials will not advocate managed care or fee-for-service Medicare. The materials will clearly state that the beneficiary does not need to take any action and are intended only to provide information.

Third Party Enrollment and Counseling. The independent third party contractor will also conduct all HMO enrollment and disenrollment activities and staff the toll free counseling call center. This neutral third party will provide objective information to Medicare beneficiaries who call seeking more information on their Medicare choices, as well as enroll beneficiaries who want to choose a managed care plan by mail or by telephone. In the competitive environment of this demonstration, managed care enrollment through a neutral third-party will help to ensure that plans do not encourage healthier beneficiaries to enroll and discourage sicker beneficiaries from enrolling in their plan. In addition, while we believe that favorable selection into Medicare HMOs

results in part from beneficiary self-selection, we are interested in learning if using a neutral third party has an effect on favorable selection into Medicare HMOs.

Another reason third party enrollment is an important part of this project is that HCFA's recent focus groups have found that Medicare beneficiaries would prefer having access to a third party (as opposed to a plan trying to "sell them something") when learning about and/or making managed care choices.

Several years ago, HCFA successfully piloted a beneficiary education and third party enrollment program in Portland, Oregon. In fact, some of the Oregon plans continued to contract with this third party after the demonstration ended. Third party enrollment is a mechanism used by many public and private sector purchasers, such as 22 State Medicaid programs, the CALPERS program, which covers over 1 million California state and local government employees, and many large employers.

Market-Based Rate Setting. Under this demonstration, Medicare's payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans would bid on a "community standard" benefit package, representing the most common plan offered in the area. The rate derived from bids will replace the current AAPCC rate. The same demographic factors now applied to the AAPCC (age, sex, Medicaid, and institutional status) will be applied to this market-based rate to adjust payment to establish the payment rate for individual beneficiaries in the first year of the demonstration. HCFA plans to apply new risk adjustment methodologies after the first year.

We have not determined yet precisely how we will set the Medicare payment based on submitted bids. We are committed to assuring that beneficiaries have access to more than one plan at the current premium level. For example, if most or all of the plans in the demonstration site are currently offering a "zero" premium option, we would set the Medicare payment rate so that several plans could continue to offer such an option.

Site Selection

In determining potential demonstration sites, we targeted those areas with a relatively high AAPCC rate, relatively low Medicare managed care penetration, and enough Medicare HMOs to make competition feasible. We are confident that we have been thorough and careful in gathering together the resources appropriate to design the demonstration. However, we also realize that we made a important mistake after we identified Baltimore as the most appropriate initial site for this demonstration. We did not adequately consult with interested parties at the local level.

Under Mr. Cardin's leadership, HCFA is now in the midst of a series of meetings, chaired by the Congressman, with others from the Maryland Congressional delegation, Baltimore managed care plans, beneficiary representatives, Baltimore business representatives, and representatives of the

State government. The purpose of these meetings is to discuss the issues and concerns raised by these parties, something we should have done earlier, but are glad to be doing now.

I'd like to take this opportunity to thank Mr. Cardin for his positive and constructive action after Baltimore was announced as the first potential demonstration site and to reiterate Secretary Shalala's commitment that we will not proceed with the demonstration until members of the Maryland delegation are comfortable with the demonstration's design and timetable.

Clarification of Demonstration's Parameters

The design and implementation of this demonstration is a complex undertaking and, hence, there are many areas where misunderstandings can occur. While it would not be possible to cover all areas, I would like clarify some of the demonstration's parameters.

First, no plan would be excluded on the basis of its submitted bid. The purpose of the bidding process is simply to set the Medicare payment amount on the basis of the managed care marketplace, rather than using the AAPCC rate. Indeed, the use of the phrase "competitive-pricing" in lieu of "competitive bidding" is intended to convey that we are only setting the price, not using the bidding process to exclude any interested parties.

Second, beneficiaries will have the option of remaining in fee-for-service Medicare or enrolling in a managed care plan. No action on the beneficiary's part is required to stay in fee-for-service Medicare. The beneficiary's enrollment in a managed care plan will be completely voluntary. The contractor conducting third party enrollment will not be rated or compensated based on the number of beneficiaries enrolling in a managed care plan. The purpose of the education and information is to assure that beneficiaries understand all their options.

Third, managed care plans will be able to market to potential enrollees as they do today through mailings and radio, newspaper, and television advertisements. Their ability to deliver their message to potential enrollees will not be hampered. This demonstration simply provides comparative information on plan choices so that beneficiaries will be able to make informed choices and conducts enrollment and disenrollment through a neutral party, instead of through the plans.

Finally, the managed care industry has for many years expressed an interest in experimenting with an MSA-wide rate, and we had indicated that we would consider using one MSA-wide payment rate. However, concerns have been raised that this could discourage plans from providing services to individuals in Baltimore City, which has the highest county-specific rate in the region. We have indicated that we are flexible on whether to use one rate for the Baltimore MSA or to adjust the bid for county differences.

CONCLUSION

Mr. Chairman, you and I and many witnesses before your Subcommittee have expressed our belief that Medicare needs to learn from the private sector by expanding the range of managed care choices available to our beneficiaries, giving beneficiaries the information they need to make informed choices, and reforming how Medicare determines its payment rate to managed care plans to incorporate local market forces. But these are complex problems and no one knows the right solutions at this time. Fortunately, our demonstration authorities allow us to test how to make these important and needed changes. We believe we have worked responsibly with experts and affected parties to craft demonstrations that will allow us to move Medicare ~~out of the "Jurassic age" and~~ into the 21st century.

I would be happy to answer any questions you may have.

We've said over and over again that we've already done so much to reform Medicare. I think it's dangerous to say we are still in the "Jurassic age."

MANAGED CARE

(Communications DRAFT 6-10-96)

President Clinton recognizes that quality managed care is a cost-effective means of delivering health care. The President supports both private and public efforts to promote quality managed care and to protect against inappropriate denial of necessary services. In both the Medicare and Medicaid programs, President Clinton is committed to ensuring quality of care for all beneficiaries, whether they are in managed care or a fee-for-service system. By working with the managed care industry to provide objective information about plan choices under Medicare, the Clinton Administration has presided over an unprecedented increase in the number of beneficiaries freely choosing managed care options. And as plan choices increase, the Administration continues to ensure that quality is preserved and improved. To better serve Medicaid beneficiaries, the Administration is providing states, managed care plans, health care professionals, and consumers with information needed to ensure high quality in Medicaid managed care plans.

Do you plan to cut the size of government, and where?

As a direct result of President Clinton's leadership and Vice President Gore's Reinventing Government efforts, we have achieved the smallest federal government in 30 years. We have cut the federal workforce by over 230,000 positions and eliminated 284 federal advisory committees. We are abolishing 16,000 pages of obsolete government regulations and rewriting 31,000 more pages of red tape. Through these efforts, we have already saved $58 billion, with $116 billion in proposed savings still to come. The era of big government is over. We are creating a smaller, more effective government that is on the side of working families.

When are HMO's going to be better regulated?

President Clinton recognizes that quality managed care is a cost-effective means of delivering health care. The President supports both private and public efforts to promote quality managed care and to protect against inappropriate denial of necessary services. In both the Medicare and Medicaid programs, President Clinton is committed to ensuring quality of care for all beneficiaries, whether they are in managed care or a fee-for-service system. By working with the managed care industry to provide objective information about plan choices under Medicare, the Clinton Administration has presided over an unprecedented increase in the number of beneficiaries freely choosing managed care options. And as plan choices increase, the Administration continues to ensure that quality is preserved and improved. To better serve Medicaid beneficiaries, the Administration is providing states, managed care plans, health care professionals, and consumers with information needed to ensure high quality in Medicaid managed care plans.

What will you do about corporate downsizing, and jobs going overseas?

President Clinton is interested in making sure that American companies continue to be the best in the world and that American workers share in the benefits of their companies and enjoy the prosperity of our overall economic growth.

Our policies of fiscal responsibility and wise investment have helped spur economic growth. The economy is the strongest in 30 years, creating 9.7 million new jobs, one million in industries such as construction and manufacturing. I don't think we should say this

We are working to invest in our people and provide them with the skills and education they need so working families can get better and high paying jobs. President Clinton has proposed to consolidate 70 overlapping job training programs into a simple voucher worth $2600 for unemployed or underemployed workers to use for community college tuition or other training. At the White House Corporate Citizenship Conference President Clinton highlighted businesses that invest in their employees with job training and education.

President Clinton's 1997 budget provides more help for workers who lose their jobs and doubles the funding since he took office--$1.3 billion in 1997. We are also working to protect the health insurance of laid off workers. President Clinton's budget helps 3.8 million Americans a year who lose their health insurance when they lose their jobs.

Increasing funding for reemployment services by 150%, enabling 400,000 more workers to participate in 1997 than in 1993

ARTICLE

Restrictions on Managed Care: Help or Hindrance?

One of the most hotly disputed areas of health insurance reform concerns the oversight of managed care. In the past year, managed care reforms were introduced in over half of all state legislatures, though only a few states actually enacted any significant legislation. Given the increasing importance of managed care in our nation's health care system, pressures to regulate the managed care industry will grow. "Any willing provider" laws—passed in 1995 by Arkansas and Wyoming—represent one of the more controversial restraints on managed care.

"Any Willing Provider" Laws. Any willing provider (AWP) laws require managed care organizations to accept into their networks all providers who are willing to agree the terms of the contract and who meet certain minimum standards. To date, 12 states have broad AWP or AWP-like laws. Another 14 states have AWP laws that apply only to pharmacies.

Effects on premiums. Many observers believe that AWP laws significantly reduce the ability of managed care organizations to hold down health insurance costs. Managed care organizations, by choosing which doctors belong to their network, can reduce costs in three main ways:

- **Insurers can contract with only the most efficient providers.** Practicing cost-effective medicine may be one of the best ways to hold down health insurance costs. Most AWP laws allow insurers to specify a broad set of criteria as minimum standards, so insurers could, in theory, specify standards that would ensure the practice of "cost-effective medicine." But writing down such standards is very difficult, and monitoring compliance with them is very costly.
- **Insurers can receive discounts in exchange for guaranteeing a large volume of patients to network providers.** Restricting the number of providers in a network ensures providers a large volume of patients and reduces patient turnover, reducing administrative and patient-search costs.
- **Large insurers may have enough market power to demand discounts from providers.** As more people enroll in managed care health plans, joining a managed care network becomes increasingly important for providers' practices. While this concentration of market power may lead to lower premiums, it may also involve a loss in efficiency as the number of providers is kept artificially low. Fear of being dropped from a network may also limit the investment providers make in developing physician-patient relationships.

Effect on consumer choice. Restricting the number of providers in a managed care network restricts patient choice. This can be particularly difficult for patients whose providers are dropped from a list of network providers: they either have to switch providers or pay substantially more out-of-pocket.

Effect on quality of care. The effect on AWP laws on quality of care is ambiguous. AWP laws may make it more difficult to exclude low-quality providers. On the other hand, some observers feel that managed care organizations often drop the higher quality providers who accept the most difficult cases because they are too costly, and reward those providers who are cheaper, rather than better.

Analysis. Over the past year, coalitions of insurers and employers have generally been successful at convincing state legislatures that restrictions on managed care could lead to increases in health insurance premiums. But, managed care is a growing and largely unregulated industry, and calls for increased regulation are likely to continue. While some degree of regulation may be warranted, it is very important that the "managed care revolution," which has successfully contained growth in health care costs, not be unduly restrained. The Administration recognized this in the proposed Health Security Act, which would have precluded states from enforcing AWP laws and required insurers to disclose what procedures were used to control utilization and costs. The Act also would have barred insurers from discriminating against providers on the basis of their patients' expected health needs.

MEMORANDUM

To: Harold Ickes
Ann Lewis
Marilyn Yager
Chris Jennings
Jen Klein

From: Steve Gleason

Date: April 15, 1996

Re: The Managed Care "Problem"

The Health Desk continues to receive voluminous requests to address perceived abuses in managed care.

The campaign's health care themes have focused on Medicare, Medicaid, and insurance reform. The question is -- should we consider expanding the insurance reform message to include references to "quality in managed care"?

PRO'S (reasons to address quality improvement in managed care):

- American Nurses Association lists quality in managed care, including OB length of stay and denial of appropriate care, as its top concern. ANA has formed a "quality coalition" with SEIU and AFSCME.

- The Catholic Health Association's primary issue for 1996 is the denial of care and the poor quality of managed care.

- SEIU of California has published extensive research on abuses in managed care. A strike against Kaiser is imminent. Like California Nurses Association, SEIU of California is sponsoring a state ballot initiative to redress these concerns.

- Richard Masur, President of the Screen Actors Guild, cited managed care quality, gag rules, and denial of care as key issues.

- Citizen Action has focused on profiteering by managed care companies as its top priority for 1996. During our meeting, Citizen Action urged the President to take a tougher stance on issues such as the gag rule, and to implement quality standards to protect consumers.

- The National Council of Senior Citizens is terrified of the prospect of coerced managed care. NCSC is demanding real choice and protections.

- AARP has published position papers warning of managed care abuses.

- The National Committee to Preserve Social Security and Medicare opened its discussion with the campaign by asking the President to take a stand on this issue.

- Of our twelve recent campaign events in California, including meetings with representatives of such groups as ANA of California, Black Nurses Association, California Hospital Association, California Medical Association, women's health activist groups, gay and lesbian coalitions, labor organizations, and HMO associations, only one meeting failed to start with an appeal for federal

action on this issue.

- Currently, there are three Democratic and three Republican bills pending in Congress that speak to this problem. (See attached.)

- There are over 60 pieces of state legislation presently pending on this issue.

- Failure to address this issue may paint the Administration as supporting abusive managed care.

- Republicans are unlikely attack a position calling for quality managed care because they would risk losing the support of both consumers and providers.

CON'S (reasons to avoid addressing quality improvement in managed care):

- Criticism of managed care may appear to be threatening to businesses that see managed care as their best opportunity to cut health care costs.

- The Administration included managed care as part of the Health Security Act and is credited with stimulating the growth of managed care to contain costs and improve preventive care. Attacking managed care now may generate a paradoxical message.

- Six of the largest managed care companies in the nation have created a fund to strike back. They may have the resources others do not have to fund advertisements critical of the Administration, should we come out front on this issue first.

- Criticism could appear to represent big government interference in private sector and state management of the health care system.

RECOMMENDATIONS:

- Address the issue in the context of support for what quality managed care has done and can continue to do for health cost containment.

- Address the issue as a sub-theme in the context of the President's position on health insurance reform.

- Add a single line to Administration and campaign position papers on health addressing concerns about abusive managed care. Example: "The President supports public and private efforts to protect consumers against poor quality medical care, fraudulent billing practices, and inappropriate denial of services by insurers and managed care companies."

- Highlight current activities of the Administration in managed care quality assurance such as the HHS Interagency Managed Care Forum, chaired by Bruce Vladek and Phil Lee, which focuses on assuring managed care quality, Medicare and Medicaid HEDIS, adaptations of the commercial sector's HMO performance measurement system; the Quality Assurance Reform Initiative, a collaborative effort of HCFA, states, the managed care industry, and consumer advocates to monitor and improve the quality of Medicaid managed care services; and the Medicare Managed Care Quality Improvement Project, a public-private partnership to develop performance measures for Medicare managed care.

- Consider an event with the Foundation for Accountability (Facct), a collaboration of public and private health care purchasers and consumer groups working to develop outcomes measures for managed care.