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Better Medical Care to Patients with Chronic Illness

Medicare and Managed Care

Medicare and Managed Care: Are We Sacrificing Quality Without Saving Money?

By Joel S. Gross, MD, and Joshua R. Shua-Haim, MD

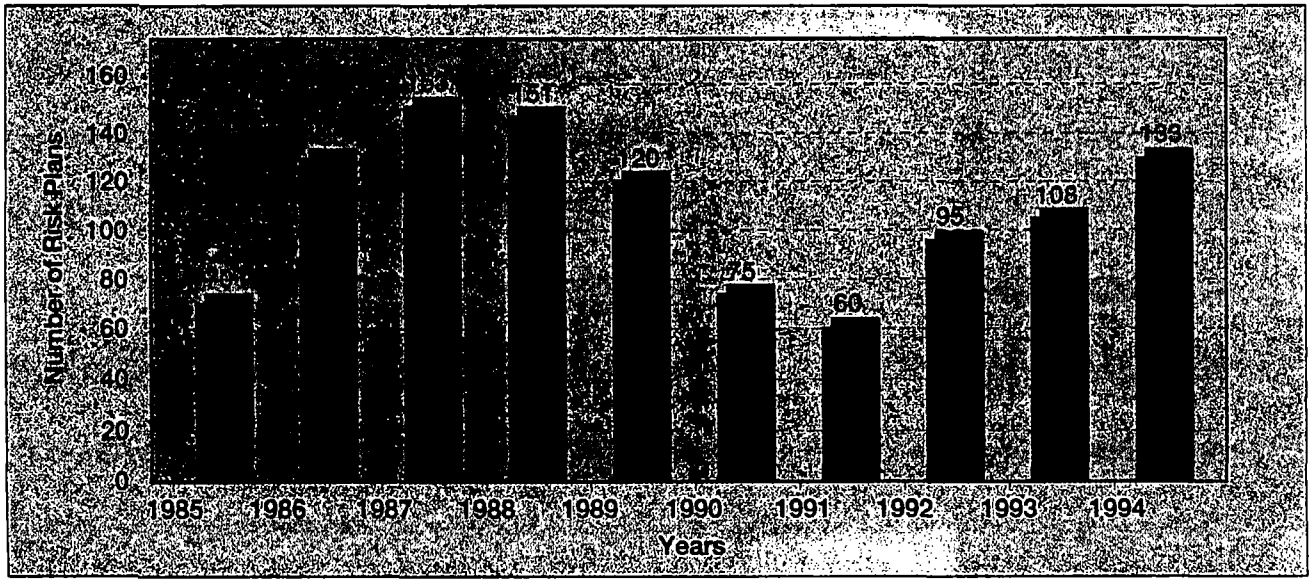
In 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) was passed by Congress and called for health maintenance organizations (HMOs) to consider offering Medicare risk contracts to senior citizens.

In 1985, 70 such contracting plans were offered to senior citizens. In 1987 that number increased to an all-time maximum of 153 plans. In 1991, the number of plans dropped to 60, only to more than double again in 1994. As of June 1994, there are 133 risk contracting plans in existence.[1]

In 1985 there were approximately 500,000 Medicare enrollees in risk plans. This number steadily increased to nearly 1.8 million enrollees in 1994. The total cost in 1993 for these Medicare HMOs was approximately $7.2 billion.[1]

Do Medicare-HMO risk plans benefit the insurer, Health Care Financing Administration (HCFA), physician and, most importantly, the patient? This article, written by two practicing geriatricians, will address this and other questions including: (1) How do Medicare-risk HMOs receive funding? (2) Are such HMOs providing high quality care to the enrollees? (3) Do Medicare HMOs reduce health care costs? (4) Are the physicians satisfied with their reimbursement under capitation or reduced fee-for-service? and (5) What lies ahead for this industry?

HCFA/Office of Managed Care — Total risk contracting plans (by year)



Medicare and Managed Care: Are We Sacrificing Quality Without Saving Money?

Historical Perspective

When insurance companies enter into a Medicare-risk contract with the federal government, the HCFA pays the HMO 95 percent of the Adjusted Average Per Capita Cost (AAPCC) per patient. This figure varies significantly with the geographic area that is served by the insurance company. For example, the 1994 AAPCC in Denver, CO totaled $412.95.[1] The figure is derived by adding the reimbursement amount for Medicare Part A services ($271.42) to that of Medicare Part B services ($140.58). Ninety-five percent of the total equals $391.40. This figure varies widely throughout the nation. The revised 1995 AAPCCs[1] indicate that one of highest rates is in Dade County, FL, where Medicare HMOs receive an AAPCC of $615.57. One of the lowest reimbursement rates is in Macon County, AL, where it is set at $274.80.

These figures represent the amount of money the HMO has available for all administrative and medical costs that are incurred throughout the year for each enrollee. Any potential profits can be realized only after all administrative and medical costs are paid. Currently, administrative overhead, including profits, varies between 15 percent and 22 percent, with an average of 18 percent nationally.[2]

Soon after the first Medicare-risk contract was issued to an HMO, certain problems began to surface. Probably one of the most glaring inadequacies of these early programs was the lack of sufficient good clinical information regarding the actual costs of providing care for older patients.

Managed care information systems (MCIS) traditionally have been poor sources of sound clinical information regarding the actual costs of health care incurred by elderly patients. Inadequate documentation of outpatient medical expenses (including costs for part B, physician services) was common. This inadequate documentation, combined with poor "actual cost" analyses by the hospitals providing inpatient care for the elderly patient, led to significant underestimation of the actual costs and at times overestimation of the true costs of comprehensive health care to senior citizens. Thus, both the insurance industry and health care providers were given very little data that were clinically and financially meaningful. Without such information, managed care companies had significant difficulty predicting what their true (total) expenditures would be versus the total costs to provide all covered services under their HCFA contractual agreement.

The HMO industry soon realized that the fastest growing segment of the population were those 85 years and older, and that patients in this group were the greatest consumers of health care dollars.

As happens with most new concepts, a learning curve was observed regarding providing care to an elderly patient in a new type of setting (e.g., a capitated environment). The HMO industry soon realized that the fastest growing segment of the population were those 85 years and older, and that patients in this group were the greatest consumers of health care dollars.[3]

These issues led some health care planners to conjecture that certain Medicare HMOs were attempting to "cherry-pick" or "cream off" the healthy 65-year-old patients. Doing so would result in substantially less expenditures by the HMO and thus greater profits. It was asserted that this selective recruiting was accomplished by making it more difficult (e.g., holding meetings at inconvenient locations) for the frail elderly to attend enrollment meetings or related seminars on health care that were offered by the insurance company.

A recent General Accounting Office report estimated that 54 to 63 percent of Medicare HMOs "enjoyed favorable selection,"[4] meaning they attracted enrollees needing substantially fewer services than average for the local Medicare population. The rest showed "neutral selection," i.e., the enrollees were about as healthy as the average elderly person in the area.

In a study that examined possible HMO marketing and selection bias,[5] the functional health statuses of approximately 300 enrollees in 22 HMOs was compared with the status of 300 nonenrollees in the same area. The study found, that although such HMOs were attracting healthier and more functionally independent senior citizens, it was unlikely that this resulted from differentially targeting healthier segments of the Medicare market. At the current time HCFA has sanctions in place making such practices illegal. Any act or acts committed to deny or discourage enrollment of patients into a Medicare HMO can result in substantial penalties with $100,000 fines levied against insurance companies found to be engaged in such practices.

It is only now that some HMOs are addressing the psychological, psychosocial, functional (i.e., activities of daily living and instrumental activities of daily living) and long-term care issues of their enrollees. By reshaping the manner in which health care delivery is offered to senior citizens (i.e., by providing pre-

ventive care rather than acute care services), more of the health care dollar will go to maintaining the elderly patient's health rather than intervening only during acute illnesses. Chronic care issues are infrequently addressed by Medicare HMOs, yet treating chronic disease in the elderly is one of our greatest health care expenses. The concept of a team approach using health care professionals from various disciplines (physical therapists, occupational therapists, pharmacists, nutritionists, psychologists, nurse practitioners and physician assistants, as well as physicians) is slowly beginning to make sense to Medicare HMOs.

Quality of Care in Medicare HMOs

Is quality care being provided to senior citizens enrolled in Medicare-HMO programs? In a recent issue of the *Journal of the American Medical Association*,[6] 6,476 HMO members with chest and joint pain were compared with 6,381 fee-for-service patients with similar symptoms regarding access to health care and reported outcomes. The results indicated that HMO patients were less likely to report seeing a specialist for care, regardless of whether the patient was suffering from acute or chronic symptoms. Health maintenance organization patients were also less likely to report that follow-up care had been recommended or that the progress of their symptoms had been monitored. Furthermore, there was less symptomatic improvement among Medicare HMO enrollees with joint pain. However, outcomes for chest pain were the same in both groups.

Another study, which looked at elderly diabetic patients enrolled in an HMO, found that the overall quality of care they were given was similar to that provided to patients in a fee-for-service setting.[7]

A recent study showed that Medicare-HMO enrollees with hypertension received equal or better care for most criteria compared with elderly hypertensive patients in fee-for-service settings.[8] A 1991 government report looked at the mortality rate among one million Medicare patients enrolled in 108 risk contract plans.[9] The results indicated that the actual number of deaths was 20 percent lower than predicted. This lower death rate suggested that either favorable selection of patients had occurred or improvement in the health status of enrollees had occurred due to superior access to care and/or superior quality of care available to the Medicare-HMO patients.

The majority of health care outcome studies that have addressed quality of care issues in Medicare HMOs have neglected to evaluate the frail elderly. As discussed earlier, it is the oldest elderly (i.e., those 85 years of age and older) who require the greatest investment of time and effort to remain functionally independent. Unfortunately, most published studies have not focused on the outcomes of these older elderly Medicare enrollees in HMOs. One of the few published articles on this subject[10] reported that the 80-year-and-over group was found to have few differences in morbidity experiences and utilization rates compared with those aged 65 to 79 years. These similarities suggest that very old non-institutionalized patients are the "health survivors" of their cohort. As such, it is conceivable that their health care needs are not much different than those of other old elderly people in terms of the types and amounts of health care service needed.

Do risk-contracting HMOs save money? A recent report by the U.S. General Accounting Office says that the cost of the Medicare risk-contract programs was 6 to 28 percent higher than what the government would have spent had enrollees chosen to stay with traditional fee-for-service programs. The report stated: "The Medicare risk-contract program has not achieved its goal of reducing Medicare cost, because HCFA's rate-setting methodology and administrative controls have proven insufficient to prevent HMOs from benefitting from favorable selection."[4]

Physicians and Medicare HMOs

A recent study[11] revealed that physicians who practice under Medicare risk contracts have mixed feelings about being members of such plans. In identifying the least liked aspects of Medicare capitation, the physicians noted that they consistently felt unable to control or disenroll abusive, noncompliant and overdemanding patients. Because HMO patients pay little or no co-payment to see their primary care doctor, certain patients frequent their capitated physicians more often than

if these doctors were reimbursed under the traditional fee-for-service model. The physicians also felt the Medicare-HMO patient management system was much more demanding and time-consuming than the fee-for-service system.

The capitated physician providing medical care to the Medicare-HMO enrollee is paid as little as $25 per patient per month. The capitated arrangement varies with individual plans; however, the majority of plans place the primary care physician at risk for delivery of a portion of the hospital pool. In the past, the hospitalized patient provided additional income to the physician. This is no longer the case. In fact, the physician now has an incentive to try to minimize the number of office visits a patient makes. Furthermore, the physician may have much less time to spend with patients when he or she does see them. In addition, the physician may try to increase the total number of covered patients in the practice. The physician may minimize the number of referrals to subspecialists. He or she may attempt to diagnose and treat conditions that a specialist might be better qualified to treat. More technical procedures may be performed by the physician, who might not have had the necessary training. If the physician wants to admit a patient to a hospital that provides a hospital-based physician for inpatient medical care, the confidentiality and continuity of the patient-doctor relationship may be disrupted. This is not the type of care to which the elderly patient easily adjusts. This trend has not yet shown a negative impact among younger senior citizens; however, as the over-85 age group continues to increase and becomes more dependent on acute care services, the overall quality of care may diminish. All these changes may result in a return to general practitioners functioning as their predecessors did 50 years ago. During that era, the knowledge available to the doctor was very limited and there was little need for subspecialists or sophisticated testing and procedures.

> The majority of health care outcome studies that have addressed quality of care issues in Medicare HMOs have neglected to evaluate the frail elderly.

Currently, physicians know their clinical limitations and appropriately refer patients to specialists when necessary. However, in the new era of HMOs, the physician may have to ignore his or her limitations and try to provide as much of the medical care a patient requires as possible. This may result in a lower quality of care for the elderly patient compared with the care currently being provided.

The Future

In the ever-changing climate of health care reform in America, making predictions is a risky endeavor. However, if we (as geriatricians) were to have our choice, senior citizens would be able to retain the traditional fee-for-service model of health care that is currently being provided by primary care physicians. Most importantly, outcome assessments and other quality-of-care studies would include an appropriate number of elderly subjects. The results of these carefully designed, controlled studies then would be used to assure cost-effective and high quality care for what should be one of our society's most cherished possessions and valuable assets: our senior citizens. M

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***Joel S. Gross, MD,** and **Joshua R. Shua-Haim, MD,** are board-certified internists who completed a two-year fellowship in geriatric medicine. Drs. Gross and Shua-Haim exclusively practice geriatric medicine in West Long Branch, NJ, and are members of the American Geriatric Society.*

SPECIAL

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

LRM NO: 2353

FILE NO: 1353

8/17/95

LEGISLATIVE REFERRAL MEMORANDUM

Total Page(s): ____

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FROM: Janet FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Report on Medicare Health Care Prepayment Plan

DEADLINE: Monday, August 28,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

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SPECIAL

RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 2353
FILE NO: 1353

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter.

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TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Report on Medicare Health Care Prepayment Plan

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am respectfully submitting the report required by the Omnibus Budget Reconciliation Act of 1990 Conference Report concerning the Medicare Health Care Prepayment Plan (HCPP) program. HCPPs are cost contractors that provide or arrange for Part B physician and supplier services under section 1833(a)(1)(A) of the Social Security Act.

Cost contracts are instruments used to pay HCPPs on a reasonable cost basis for providing Medicare-covered services to beneficiaries enrolled in the health plan. This report describes conditions under which HCPP contractors are required to provide or arrange for services. It also details the extent to which beneficiaries are afforded access to grievance procedures, secretarial review of marketing materials, and circumstances under which beneficiaries may enroll in HCPPs. Finally, this report discusses the Medicare Part A and B costs of beneficiaries enrolled in HCPPs.

I am also sending a copy of this report to the Speaker of the House of Representatives, the Chairman of the Committee on Finance of the Senate, the Chairman of the Committee on Ways and Means of the House of Representatives, and the Chairman of the Committee on Energy and Commerce of the House of Representatives.

Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

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Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Robert Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

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Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable William Archer
Chairman, Committee on
Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

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Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Thomas J. Bliley
Chairman, Committee on Energy
and Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am respectfully submitting the report required by the Omnibus Budget Reconciliation Act of 1990 Conference Report concerning the Medicare Health Care Prepayment Plan (HCPP) program. HCPPs are cost contractors that provide or arrange for Part B physician and supplier services under section 1833(a)(1)(A) of the Social Security Act.

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Sincerely,

Donna E. Shalala

Enclosure

Report to Congress
on
Health Care Prepayment Plans

Donna E. Shalala
Secretary of Health and Human Services
1995

Table of Contents

Executive Summary

1. Introduction

This report responds to a request made in the Conference Report accompanying the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508 (OBRA 90). In the Conference Report, Congress asked the Secretary of the Department of Health and Human Services to review:

(1) the conditions under which organizations with health care prepayment plan (HCPP) agreements are required to provide or arrange for all Part B items and services;

(2) the extent to which beneficiaries in HCPPs are accorded access to a grievance procedure and Secretarial review of marketing materials;

(3) circumstances under which beneficiaries may enroll in HCPPs; and

(4) Medicare Part A and Part B costs of beneficiaries enrolled in HCPPs compared to beneficiaries not enrolled in HCPPs.

The term HCPP is used to describe health care organizations authorized by section 1833(a)(1)(A) of the Social Security Act (the Act) which enter into written agreements with HCFA to receive Medicare Part B payment on a reasonable cost basis rather than based on the reasonable charge or fee schedule for each covered service the organization furnishes.

Additionally, while OBRA 90 provides exemptions from Medigap legislation (section 1882 of the Act), the Social Security Act Amendments of 1994, provide that the exemption will expire on December 31, 1995. Because union and employer HCPPs remain exempt from Medigap standards under section 1882, only commercial HCPPs will be affected.

2. Background

When Medicare was established in 1965, prepaid health care organizations that did not want to utilize fee-for-service payment systems (i.e., be paid on a reasonable charge basis) could receive Medicare payments only through HCPP agreements. These organizations that elected to be HCPPs were paid on the basis of reasonable costs. Organizations entering HCPP agreements today fall into three categories:

(1) employer or union-sponsored clinics offering outpatient services;

(2) clinics serving vulnerable populations (e.g. Medicare/Medicaid dual eligible populations; disabled, underserved and minority populations);

(3) comprehensive health care plans, often federally qualified health maintenance organizations (HMOs).

In 1982, amendments to Section 1876 of the Act permitted certain prepaid health organizations (HMOs) and competitive medical plans (CMPs) to enter into full risk or cost contracts to provide Medicare services on a prepaid basis. Congress retained the HCPP option, which continued to be available to all prepaid plans. It was used primarily by employer or union-based prepaid health organizations which were unable to qualify as risk or cost contractors under section 1876. Recently a number of organizations with risk or cost contracts (i.e., organizations able to meet section 1876 criteria) have been converting to HCPP contracts because they prefer the payment method and the less stringent regulatory environment under which HCPPs operate. Other organizations have historically exercised their HCPP option to avoid the open enrollment requirements of section 1876.

In late 1994, 360,000 Medicare beneficiaries were enrolled in open-enrollment HCPPs, while 228,000 were enrolled in closed-enrollment HCPPs. (Closed-enrollment plans consist of "grandfathered" enrollees who chose to stay in the HCPP when the plan converted to a section 1876 cost or risk contract.) We are concerned about the lack of authority to conduct oversight of these contractors. Because there is little statutory or regulatory authority to govern HCPPs, beneficiaries have significantly less protection than they have under either risk or cost contracts. Additionally, because HCPPs are not required to be organized under state laws, many HCPPs are not regulated by states. Medicare beneficiaries, therefore, face the risk of enrolling in entities that may not be legally and medically accountable to their patients.

The focus of this report is on the limitations in section 1833(a)(1)(A) which impede our ability to regulate and oversee HCPP agreements in ways that provide meaningful safeguards for beneficiaries, and HCPP's associated providers. As such, this report is not a criticism of organizations with HCPP agreements. Instead it identifies areas where our experience administering section 1876 contracts provides the basis for recommending specific changes in the section 1833 authority to provide meaningful safeguards and protections for all concerned.[1]

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[1]Section 1876 governs cost and risk contractors. Many HCPPs are similar to organizations with 1876 contracts.

3. Limited Oversight Authority

The Health Care Financing Administration (HCFA) currently lacks the oversight authority to ensure that HCPPs provide beneficiary and program protections comparable to those found in section 1876 risk and cost contracts. Specifically, HCFA lacks the authority to ensure that HCPPs:

- provide full and adequate disclosure to beneficiaries and HCFA about the range of services provided, specifically a description of covered and noncovered services,
- submit separate cost and premium reports for each geographic area served by the HCPP,
- submit premium rates and other beneficiary charges to HCFA for prior approval,
- institute grievance procedures,
- submit marketing materials and practices to HCFA for review,
- submit enrollment and disenrollment procedures to HCFA for review,
- institute utilization review procedures,
- adhere to physician incentive plan requirements,
- meet minimum standards for keeping financial records,
- provide hold-harmless protection for beneficiaries in the event of fiscal insolvency or termination of HCPP agreement, and
- be subject to relevant civil money penalty and intermediate sanction provisions required for section 1876 contractors.

Report to Congress
on
Health Care Prepayment Plans

I. Introduction

This report responds to a mandate made in the Conference Report accompanying the Omnibus Budget Reconciliation Act of 1990. In the Conference Report, Congress asked the Secretary of Health and Human Services to review:

- the conditions under which organizations with health care prepayment plan (HCPP) agreements are required to provide or arrange for all Part B items and services;
- the extent to which beneficiaries are accorded access to a grievance procedure and Secretarial review of marketing materials;
- circumstances under which beneficiaries may enroll in HCPPs; and
- Medicare Parts A and B costs for beneficiaries enrolled in HCPPs compared to costs for beneficiaries not enrolled in HCPPs.[2]

Congress exempted HMOs, CMPs and HCPPs from the detailed Medigap rules it enacted in OBRA 1990. The OBRA 1990 conferees were concerned, however, that such an exemption might not be appropriate for HCPPs in light of differences between protection offered beneficiaries enrolled in HMOs or CMPs and those offered HCPP enrollees. The Social Security Act Amendments of 1994 eliminated the exemption, however, and HCPPs will have to comply with Medigap rules beginning January 1, 1996.

II. Background

A. General Background

HCPPs evolved from the original arrangement the Medicare program had with prepaid health plans. An HCPP is a health organization which has executed a written agreement with HCFA to receive payment on a reasonable cost basis from HCFA for provision of some Medicare Part B services. These Part B services include some or all Medicare-covered physician and supplier services; they do not

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[2]See House Conference Report 964, 101st Congress, 2nd Session, 805;x.

include hospital outpatient services. Legislative authority for HCPPs consists of the following sentence fragment in section 1833(a)(1)(A) of the Act pertaining to payment of benefits under Supplemental Medical Insurance (Medicare Part B):

> ...except that (a) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b)...

Under section 1833(a)(1)(A) HCPPs can receive Medicare Part B reimbursement on a reasonable cost basis, rather than receiving payment on a reasonable charge (i.e., fee-for-service) basis. HCPPs receive an interim monthly payment based on projected costs for serving enrolled members. They must submit an annual cost report which HCFA uses to determine retroactive payment adjustments based on the HCPP's actual costs of delivering services. Reported costs must be reasonable as determined by HCFA.

Organizations with section 1833 agreements may be paid directly only for physician and supplier services. Further, they are not required to provide all Medicare physician and supplier services. HCPPs may not be paid directly for any Part A services (i.e., inpatient hospital, skilled nursing facility, or home health), or for Part B services processed by intermediaries, such as hospital outpatient services. Most comprehensive health care organizations with HCPP agreements also provide or arrange for Medicare Part A services and most, if not all, Part B services. Part A providers associated with HCPPs receive Medicare payment by submitting claims to Medicare intermediaries as do other fee-for-service providers. Employer and union-based plans typically do not arrange for Part A services.

HCFA is required to sign an HCPP agreement with any entity (union, employer or commercial) capable of meeting eligibility criteria. In addition to having little discretion in signing these agreements, HCFA has little discretion in terminating them. This abbreviated oversight ability inhibits the agency's ability to assure Medicare enrollees in HCPPs will have the same protections as Medicare enrollees in other managed care products.

An HCPP, by definition, refers only to the physician and supplier *payment mechanism* for the Medicare enrollees of an organization. HCPPs may be small clinics serving a single employer or union group. They also may be large, well-established federally qualified health maintenance organizations (FQHMOs) and other large organizations which could qualify as competitive medical plans (CMPs) under section 1876 of the Act. An HCPP usually serves non-Medicare enrollees as well, but, unlike HMOs and CMPs with contracts under section 1876, is not required by statute to do so.

B. History of HCPPs

With the inception of Medicare in 1965, Group Practice Prepayment Plans (the precursor to HCPPs) were established pursuant to the statutory authority now contained in section 1833(a)(1)(A). The statute sought to accommodate the payment problems of large prepaid health care organizations as well as union and employer clinics. Billing Medicare fee-for-service was burdensome and difficult for these group practices because of their organizational structure. These group practices were paid by their clients on a prepaid premium basis and did not pay their physicians on a fee-for service basis. Consequently, they did not bill patients and had little experience with claims submission.

During the late 1960s and early 1970s, various other types of prepaid plans were created while other longstanding models, such as HMOs, became increasingly prevalent. As HMOs and other prepaid plans became interested in providing services to Medicare beneficiaries, they were allowed to enter contracts with HCFA to serve Medicare beneficiaries.[3] However, many prepaid plans found these rules complex, burdensome, and barriers to participation. In response, Congress enacted legislation to simplify Medicare prepaid contracting rules.[4] Section 1876 governs Medicare contracts and payment procedures with prepaid health plans that cover all Part A and B benefits. However, in contrast to section 1833, section 1876 delineates a wide range of requirements designed to protect beneficiaries and the Medicare trust funds.

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[3]Beginning in 1976, HMOs and other prepaid plans were given the option to receive payment on a cost or modified risk basis.

[4]The Tax Equity and Fiscal Responsibility Act of 1982. These contracts are sometimes referred to as "TEFRA risk" or "TEFRA cost" contracts.

Because the legislative authority in section 1833(a)(1)(A) only addresses payment, regulations implementing the authority are restricted to payment rules. The regulations do not address accountability to beneficiaries, accountability to HCFA, health care delivery and quality, and other requirements found in section 1876. For example, the original requirements implementing section 1833(a)(1)(A) only specified that plans had to have at least 3 full-time equivalent physicians and that the physicians had to be prepaid, not paid on a fee-for-service basis.

A HCFA-wide workgroup was formed to evaluate the Health Care Prepayment Plan option. This workgroup was charged with examining HCPPs' value to HCFA and beneficiaries in providing managed care, beneficiary protections, and cost-efficient quality care. In addition, the workgroup was to recommend where and how HCPPs could fit in the continuum of Medicare choices which range from an indemnity program to a full lock-in comprehensive HMO program. Because Congress' request in the Conference Report accompanying OBRA '90 encompasses the workgroup's task, this report includes the results of the workgroup's analysis.

C. HCPPs and Managed Care

Health Care Prepayment Plans are one choice among the growing continuum of Medicare options. These options are: Medicare fee-for-service; Medicare SELECT; HCPPs; section 1876 cost-based contracts; and 1876 risk contracts. (Please refer to Appendix I for definitions of terms used in this report.) As of December 1994, over 3.1 million beneficiaries are enrolled in Medicare managed care plans (HCPPs, section 1876 cost and section 1876 risk contracts). Because we believe the level of regulations under section 1876 is appropriate for all managed care plans, this report compares section 1833 contract requirements with section 1876 contract requirements and highlights the differences.

HCFA has traditionally viewed HCPP agreements as a means to enable employer and union-based clinics (not able to meet section 1876 contract requirements) to receive Medicare Part B payment. Additionally, many organizations otherwise eligible for section 1876 contracts have used the HCPP mechanism as a vehicle to gain Medicare experience without assuming financial risk. These otherwise eligible organizations see several advantages to HCPP contracts over those governed by section 1876. In particular:

- HCPPs are not required to conduct annual open enrollment;

- HCPPs are permitted to health screen Medicare beneficiaries, so long as they screen all of their enrollees;

- HCPPs are permitted to age-rate their premiums.

In December 1994 there were 70 HCPPs with 591,000 enrollees. By comparison, there were 29 section 1876 cost contractors with 174,000 enrollees and 154 section 1876 risk contractors with 2,268,000 enrollees. Thirty-four out of 70 HCPPs were FQHMOs, making them eligible to apply to contract with HCFA under section 1876. Twelve were employer or union groups which would not qualify under section 1876. Based on available information, we believe the remaining 24 may qualify as CMPs under section 1876.[5] In sum, of 70 current HCPPs, we believe only a fraction (between a 12 and 20) would be incapable of meeting section 1876 standards.

The remainder of this report provides a discussion of the issues that Congress asked the Secretary to address. Also included are discussions regarding additional issues identified by HCFA.

III. Requested Issues and Discussion

Appendix II is a comparison chart outlining the differences between section 1833 agreements and section 1876 contracts. Unlike section 1876, section 1833 imposes no organizational requirements other than HCPPs be prepayment health care organizations serving enrolled members. The absence of other requirements insulates HCPPs from a number of legislative provisions found in section 1876 of the Act that protect both beneficiaries and the Medicare program.

The following section compares section 1876 contract requirements with section 1833 HCPP requirements in several areas. Section 1876 contracts are available for prepaid health care organizations that provide comprehensive health care services to Medicare beneficiaries. Shaped by law, regulations, and HCFA's operational experience, these requirements are a good frame of reference when discussing HCPP requirements.

A. Provision of Services

HCPPs are not required to provide the full range of Medicare Part B services (and they cannot be paid for providing Part A services). At their option, HCPPs

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[5]CMP eligibility cannot be determined until an application is filed for a section 1876 contract.

may provide or arrange for any combination of Part B services (though some, such as outpatient hospital services, HCPPs cannot be paid for). Part B services include:

- physician's services;
- diagnostic x-ray tests;
- laboratory and other diagnostic tests;
- outpatient hospital services;
- ambulance;
- emergency or urgently-needed care received outside the HCPP's network;
- outpatient treatment of mental illness;
- drugs and biologicals that cannot be self-administered;
- transfusions of blood and blood components;
- medical supplies;
- durable medical equipment;
- physical and occupational therapy and speech pathology services;
- care from Medicare-approved practitioners such as certified registered nurse anesthetist, certified nurse midwife, physician assistant, clinical psychologist;
- home health services if not covered by Part A;
- renal dialysis;
- prosthetic devices;
- vaccines;
- hemophilia clotting factors;
- antigens; and
- immunosuppressive drugs.

Section 1876 contractors, unlike HCPPs, must provide or arrange for the full range of Medicare covered Part A and Part B services. In addition, many section 1876 contractors provide non-Medicare covered services such as preventive care, hearing and vision exams, eyeglasses, hearing aids, prescription drugs, and dental benefits. Thus, beneficiaries enrolled with risk or cost contractors have little incentive to seek care from an outside provider. These beneficiaries also face financial disincentives to seek care from an outside provider. Risk plan enrollees are liable for the full cost of services not authorized by the plan; cost plan enrollees are liable for conventional Medicare coinsurance and deductibles. Finally, many section 1876 plans coordinate specialty and inpatient care through a primary care physician. This helps assure that patients receive effective care from an appropriate provider in a cost-efficient and appropriate setting.

HCFA does not know the number of HCPPs offering the full range of Part B services. In contrast, HCFA knows that all section 1876 contractors provide all covered Part A and B services. HCFA also knows whether a section 1876 contractor offers non-Medicare service(s) and the type and cost of the service(s).

The lack of oversight authority and requirements to provide comprehensive benefits raises several concerns. First, beneficiaries enrolled with HCPPs may be unaware of discrepancies that may exist between Part B benefits and their HCPP's benefits. For example, the HCPP may not make it clear to enrollees that Medicare covers services beyond those available from the HCPP and hence, these beneficiaries may forgo needed services in the mistaken belief that Medicare does not cover them. Second, program evaluation and monitoring is more difficult when HCPPs are not required to provide uniform types and levels of services.

Because HCPPs are not required to provide comprehensive benefits, beneficiaries enrolled in HCPPs are more likely to seek care outside the plan than a risk or cost patient would. If a patient self-refers outside the HCPP for care without notifying his or her primary care physician, the patient will receive fragmented care. Additionally, HCPP members have copayments for a portion of covered services. This could lead to beneficiaries paying for duplicative coverage if they also find it necessary to buy medigap insurance to recoup their out-of-pocket costs.

Availability and Accessibility of Services

Section 1876 contractors must assure that providers are available and accessible to Medicare enrollees throughout the plan's geographic service area. Therefore, a section 1876 plan must have sufficient numbers and types of primary care physicians, specialty practitioners, hospitals, nursing homes and other types of providers and facilities within the organization's service area to provide care adequately for its members.

Contractors are also required to assure that enrolled beneficiaries have the same level of access to Medicare covered services as beneficiaries have under Medicare fee-for-service. HCPPs are not required to assure the availability and accessibility of practitioners or equal access. HCPPs also are not required to define a service area from which they enroll beneficiaries.

The lack of such requirements for HCPPs poses concerns about beneficiary protection. For instance, a Medicare beneficiary may join an organization with an HCPP agreement because a certain physician group is located near his or her home. If the contract between the HCPP and the physician group is not renewed, HCPPs are not currently required to replace the physician group with another one located nearby, to meet availability or accessibility of services.

Because HCPPs are not required to be organized under state laws, a state may not have the authority to require the HCPP to assure an appropriate distribution of providers within an area.

B. Grievance Procedures

Grievance procedures are a set of rules or processes available to an enrollee to resolve all complaints affecting issues other than the provision of Medicare services furnished by the organization. Grievance procedures are distinct from the formal appeals process. The Medicare appeals process is used by beneficiaries to resolve disputes affecting the beneficiary's right with regard to Medicare services furnished by the organization. Medicare appeals are available to all beneficiaries except those enrolled in HCPPs. However, regulations were issued in November 1994 to make appeals available to HCPP enrollees effective May 1995.

Grievance procedures are unique to managed care organizations, serving a valuable purpose in providing such organizations with feedback on patient satisfaction while furnishing enrollees the opportunity to raise issues, concerns or complaints. Such procedures can serve as a tool for assessing enrollee satisfaction or dissatisfaction with:

- the waiting time to schedule appointments with physicians;
- the time a patient spends in the waiting room to see a doctor;
- the geographical distribution of hospitals, clinics and medical groups offered by the organization;
- the medical practitioners associated with the organization; or
- the helpfulness of specific medical and non-medical personnel associated with the organization.

Section 1833(a)(1)(A) does not require HCPPs to establish grievance procedures to resolve beneficiary complaints; however, those HCPPs which are also FQHMOs must have grievance procedures for all enrollees which, by definition, would include Medicare beneficiaries enrolled in HCPPs. Information on grievance procedures must be provided in writing to enrollees of all FQHMOs.

HCPPs that are not FQHMOs, by contrast, are not required to have grievance procedures in place for Medicare beneficiaries. This is a clear departure from safeguards found in section 1876 risk and cost HMOs. At present, there are 30 HCPPs that are not FQHMOs, and HCFA has no way of knowing whether

grievance procedures are available or not. Without a formal grievance procedure, factors contributing to enrollee dissatisfaction may not be recognized and adequately addressed by the HCPP. Many organizations also use such feedback when evaluating staff performance. The results of grievance procedures also shape strategic planning efforts for some organizations.

C. Marketing

Section 1833(a)(1)(A) is silent on the subject of marketing, whereas section 1876 is clear on an organization's obligations regarding marketing material review and acceptable marketing practices. Because the Department lacks authority to review HCPP marketing material, there is no oversight of marketing practices.

Marketing Material Review

Marketing material consists of such items as the organization's marketing brochures, enrollment forms and information packets, and advertisements. Section 1876 organizations must submit all marketing material to HCFA for review prior to its use. Such prior approval is not authorized by the statute governing HCPPs. (Though Some HCPPs voluntarily allow HCFA staff to review marketing materials prior to distribution to HCPP enrollees and prospective enrollees.)

Prospective review of marketing material helps prevent incorrect information from being disseminated to Medicare beneficiaries. Marketing material review is necessary to assure that the plan correctly informs Medicare beneficiaries about their rights and responsibilities, the premium and other charges they have to pay, and medical benefits to which they are entitled. Without reviewing marketing material, HCFA has no proof that the premium reported to HCFA by the HCPP is the same premium being offered to beneficiaries or that the benefits being reported to HCFA for reimbursement match the benefits being advertised to the beneficiaries. If the HCPP does not provide certain Medicare covered services, HCFA cannot assume that the marketing material informs beneficiaries which services are not provided and that beneficiaries can receive these services out-of-plan. Finally, HCFA cannot assure that marketing material informs beneficiaries of the consequences of receiving out-of-plan service: they are likely to have to pay their own Medicare coinsurance and any unpaid deductible in addition to having to pay the plan's monthly premium.

Marketing Practices

Because HCFA does not have the authority to monitor HCPP marketing

activities, we do not know which types of marketing practices HCPPs use. HCFA is therefore unable to prevent an HCPP's use of marketing practices that are prohibited for section 1876 contractors. Such practices include door-to-door solicitations, placing pressure upon Medicare beneficiaries to enroll, or presenting HCPP marketing representatives as Medicare consultants or HCFA employees. Again, HCFA has greater authority over section 1876 contractors. For example, HCFA has the authority to review marketing practices and assure that section 1876 contractors do not engage in unacceptable marketing activities. Further, HCFA has the authority to impose civil money penalties or intermediate sanctions for section 1876 abuses - an authority not available against HCPPs.

D. Enrollment/Disenrollment Procedures

Health Screening

The statute governing HCPPs does not specify precise circumstances under which beneficiaries may enroll in HCPPs. However, current regulations do impose some limits on HCPPs' practices. An organization with an HCPP agreement may health screen, or deny enrollment or disenroll a member on the basis of health status, if the organization uses the same criteria for its non-Medicare enrollees. For example, if an organization with an HCPP agreement health screens all enrollees for any existing medical condition that could lead to high use of medical services, it could refuse to enroll a Medicare beneficiary with such a condition. Furthermore, if an enrollee develops such a condition while an HCPP member, the HCPP could expel the enrollee for that condition. In contrast, section 1876 plans may not health screen except for beneficiaries who have end-stage renal disease (ESRD). In addition section 1876 plans may not expel members for any health conditions, including members who develop ESRD after enrollment.

Enrollment Process Requirements

Section 1833(a)(1)(A) leaves Medicare beneficiaries vulnerable to arbitrary enrollment and disenrollment practices. An HCPP may enroll or disenroll as many or as few Medicare beneficiaries as it wishes, using any process it prescribes. HCPPs are not restricted to enrolling only beneficiaries living within a defined service area. As a result, HCPP enrollees may be paying premiums for services that would be judged to be inaccessible under section 1876 standards. HCFA has no regulatory authority to prescribe or monitor enrollment and disenrollment procedures used by HCPPs. Because HCFA lacks the authority to monitor HCPPs in this area, we do not know whether beneficiaries are adequately protected during the enrollment and disenrollment process. In contrast, section 1876 contractors must follow certain enrollment/disenrollment procedures designed to balance the needs of the

organization with the protection needed by beneficiaries.

E. Cost Comparison

The OBRA '90 conference report asks the Secretary to review Medicare Part A and B costs of beneficiaries enrolled in HCPPs compared with beneficiaries enrolled under Medicare's risk and cost managed care contracts.

HCFA's Office of Managed Care (OMC) performed an initial analysis based on in-house operational data to better understand both payment to HCPPs and enrollee use of out-of-plan services. Although OMC's data was insufficient to fully compare section 1883 HCPP expenditures with those of demographically similar beneficiaries enrolled in section 1876 risk and cost contracts, preliminary results indicate significantly higher payments to HCPPs. Moreover, preliminary findings also show wide variation among HCPPs in out-of-plan service rates.

Subsequent to OMC's analysis of cost issues, HCFA's Office of Research and Demonstrations awarded a contract to Mathmatica Policy Research in mid-1993 which, in significant part, will address this question. The evaluation is expected to be complete in late-1995 and, among other issues, will evaluate aspects of the HCPP program including:

- the cost effectiveness of the HCPP program;
- costs of HCPPs relative to risk contracts;
- costs of HCPPs relative to fee-for-service Medicare;
- biased selection into HCPPs;
- why plans convert from risk to HCPP contracts;
- the likelihood of plan entering risk contracts in the absence of the HCPP option; and
- the incidence of duplicate payments (payments for the same service made to HCPPs and other Medicare managed care entities when payment is also made to the supplier/provider through fee-for-service payment mechanisms).

IV. Additional Issues

Under section 1876 contracts, HCFA can refuse to enter into a contract with an organization on the basis that it does not have an internal quality assurance program and/or that it does not meet fiscal soundness and solvency requirements. No such safeguards exist under section 1833. Therefore, neither Medicare beneficiaries nor HCFA have protection against organizations which operate with

no defined standards of quality of care and offer no assurance of financial stability.

A. Quality Assurance

Currently HCFA cannot refuse to enter into an HCPP agreement with an organization which does not have an internal quality assurance program and operates with no defined standards for health care quality. Organizations contracting under section 1876, in contrast, are required to implement quality assurance programs. These programs are monitored by HCFA. Beneficiaries enrolled in HCPPs have no guarantee that their care is subject to a quality assurance program. Hence, extending this requirement to HCPPs is likely to enhance care provided by HCPPs.

Physician Incentive Payments

HCPPs are not subject to requirements regarding physician incentive payment plans. Certain types of physician incentive plans place physicians at substantial financial risk that could result in incentives to withhold medically necessary services. To address this concern, Congress mandated that the Secretary issue rules which prescribe the manner in which organizations with contracts under section 1876 can provide incentive payments to physicians (section 4204 of the Omnibus Budget Reconciliation Act of 1990).

B. Sanctions and Penalties

Section 1876 provides HCFA the authority to impose intermediate sanctions and civil money penalties on contracting HMOs and CMPs. Such sanctions can be imposed in cases where the deficiency is not serious enough to terminate the contract. HCFA has no similar authority under section 1833. Absent such authority, HCFA has only two choices when an HCPP has a minor deficiency. First, HCFA can use informal persuasion to request the HCPP to alter its practices; second, in extremely limited cases, HCFA can terminate the HCPP's agreement.

We note that HCPPs may engage in activities that would be subject to civil money penalties if they contracted under section 1876 (e.g., health screening, failure to pay claims in a timely manner, and specific inducements to withhold a specific medically necessary services.)

V. Conclusions

Legislative authority for HCPPs consists of a sentence fragment in section 1833(a)(1)(A) of the Social Security Act pertaining to payment of benefits under

the supplementary medical insurance program (Medicare Part B). Originally section 1833 was intended to be used by prepaid group practices (usually union or employment based) which were incapable of complying with Medicare's fee-for-service billing structure. HCPP participation was not explicitly restricted to these union or employment-based plans, however, and, in time, a number of commercial entities applied for HCPP contracts. Unlike union- and employment-based plans, many of the commercial entities were capable of meeting section 1876 standards but opted for HCPP contracts to avoid the more rigorous standards found in section 1876. Additionally, because HCPPs are not required to be organized under state laws, many HCPPs are not regulated by states. This situation raises concerns about quality assurance in HCPPs, cost containment and accountability issues, and beneficiary protection for HCPP enrollees.

HCFA has limited authority under law and regulation to address many of the problems identified in this report. In the case of commercial HCPPs, the agency does not have the authority to:

- limit the HCPP option to those entities that are unable to qualify for section 1876 contracts
- require current HCPPs that qualify for section 1876 contracts to meet section 1876 requirements if they wish to continue contracting with Medicare
- specifically address Congressional concerns regarding service provision, grievance and enrollment procedures
- ensure that HCPPs are capable of providing the full range of Medicare covered Part A and Part B services;
- ensure that providers are available and accessible to Medicare enrollees throughout a defined geographic area
- ensure HCPPs have a grievance process to resolve beneficiary complaints
- require HCPPs to receive prior HCFA approval of marketing materials
- require HCPPs to receive prior approval of enrollment and disenrollment procedures to ensure they meet minimum standards
- prevent health screening of Medicare beneficiaries (other than ESRD, which is permitted under section 1876)
- ensure HCPPs meet internal and external quality assurance requirements
- ensure HCPPs meet Federal requirements regarding incentive payments to physicians

- ensure HCPPs meet fiscal solvency, financial record keeping, and insolvency protection requirements

- subject HCPPs to civil money penalties and intermediate sanctions

In the case of union/employer-based HCPPs and those serving vulnerable populations, which would not be able to quality for section 1876 contracts with HCFA, the agency lacks the authority to:

- ensure full and adequate disclosure to beneficiaries and HCFA about services provided;

- require submission on of separate cost and premium reports for each geographic area served by the HCPP;

- require submission of premium rates and other beneficiary charges to HCFA for prior approval;

- require institution of grievance procedures to resolve beneficiary complaints;

- require HCFA review of marketing materials and practices;

- require HCFA review of enrollment/disenrollment procedures;

- require institution of utilization review procedures;

- require adherence to physician incentive plan requirements;

- require minimum standards for keeping financial records;

- require hold-harmless protection for beneficiaries in the event of fiscal insolvency or termination of HCPP agreement; and

- initiate civil money penalties and intermediate sanctions.

It should be noted that, even under expanded HCPP regulatory authority, Medicare beneficiaries in union, employer and vulnerable population plans will continue to have the choice to enroll in either the fee-for-service Medicare or section 1876 (risk or cost) plans serving their area, just as any other Medicare beneficiary would.

With respect to costs, HCFA is concerned about overpayment. The evaluation cited earlier should provide a better understanding of this when it's completed in late-1995.

Definition of Terms Used in This Report

Carriers	Entities which contract with HCFA to process Medicare Part B claims from physicians and other suppliers.
Competitive Medical Plans (CMPs)	CMPs are prepaid health care plans that meet the definition of §1876(b)(2) of the Social Security Act. CMPs contract with HCFA under §1876. These organizations are similar to federally qualified HMOs in structure and provide both inpatient and outpatient services. CMPs are not federally qualified, but qualify for Medicare contracts under section 1876 of the Social Security Act by meeting the definitions of §1876(b)(2).
Federal Qualification	The status granted by HCFA to prepaid health care organizations which meet specific administrative, legal, fiscal, quality assurance and benefits requirements as specified in Title XIII of the Public Health Service (PHS) Act.
Federally Qualified HMOs	HMOs that are certified by HCFA as meeting Federal Qualification requirements and which automatically qualify to apply for Medicare contracts under section 1876.
Health Care Financing Administration (HCFA)	HCFA is the Federal agency which administers the Medicare, Medicaid, and federally qualified HMO programs. HCFA is a component of the Department of Health and Human Services (DHHS).
Health Care Prepayment Plans (HCPPs)	Organizations which have an agreement with HCFA under §1833(a)(1)(A) of the Social Security Act to receive Part B payment on a "reasonable cost" basis rather than receiving eighty percent of the "reasonable charge" for services provided.

Health Maintenance licensed Organizations (HMOs)	Prepaid health care organizations that are under state law. (In the context of this report.)
Intermediaries	Entities which contract with HCFA to process Medicare claims submitted by providers.
Managed Care	A health care system which provides organizational oversight to health care delivery so that the appropriate care is provided by the appropriate health care provider in the right setting.
Medicare Fee-for-Service (FFS)	The traditional Medicare payment system. Claims for individual physician and hospital services, or other inpatient and outpatient services, are submitted by providers to Medicare carriers and intermediaries for payment.
Medicare Part A	Part A of Medicare helps pay for covered inpatient hospital and nursing home stays, home health care, and hospice care.
Medicare Part B	Part B of Medicare helps pay for all non-Part A services that are covered by Medicare. Examples include: outpatient hospital services, physician services, medical supplies, durable medical equipment, outpatient therapies, and ambulance services.
Medicare SELECT	A Medicare supplement insurance policy combined with a network of health care providers, supplemental coverage is generally only available if network providers are used. Medicare SELECT was authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) and implemented in 15 states in 1992.

Comparison of Medicare Contract Requirements for Risk and Cost HMO/CMPs and Health Care Prepayment Plans*

SECTION** 1876 RISK CONTRACT	SECTION 1876 COST CONTRACT	SECTION 1833 HEALTH CARE PREPAYMENT PLAN
1. Eligibility and Contracting Requirements		
• HMO/CMP must be organized under state law and be a federally qualified HMO or a CMP. §417.404 - 417.418	• Same as risk.	• Organization (HMO, group practice, or Taft-Hartley union trust) must furnish physician services to enrolled members through its employees, or under formal arrangements with a medical group, IPA, or individual physicians. §417.800(b).
• Have at least 5,000 enrollees. §417.410(e)(2), 417.413(b)	• Have at least 1,500 enrollees.	• No minimum enrollment requirement. §417.413.(c)(1)
• Have at least 75 Medicare enrollees or an acceptable plan for achieving within two years.** §417.410(e)(3)	• Same as risk** §417.413(c)(2)	• No minimum Medicare enrollment requirement.
• Have not previously terminated or failed to renew a risk contract within the preceding 5 years. §417.410(e)(5)	• Not applicable.	• Not applicable.
• Satisfy HCFA that it can bear the potential losses of a risk contract. §417.410(e)(4)	• Qualifies for a risk but chooses a cost or meets all conditions for a risk contract except that HCFA does not judge the organization capable of bearing the potential losses. §417.410(f)	• Not applicable.

* Chart Prepared by the Group Health Association of America with the assistance of the Health Care Financing Administration (Updated February 1995)

** "Section" refers to sections of the Social Security Act. § refers to 42 C.F.R.

RISK CONTRACT	COST CONTRACT	HEALTH CARE PREPAYMENT PLAN
	2. Benefits and Premiums	
• Members are "locked-in" to receiving covered services (except emergency services anywhere and urgently needed services out-of-area) from the HMO/CMP. §417.440, 417.448	• No lock-in. Members may receive covered services outside the HMO/CMP and be reimbursed by Medicare, and pay their own Medicare copayments and deductibles. Out-of-plan emergency services and out-of-area urgently needed services are covered by the HMO/CMP.	• Same as cost (except there is no provision in the HCPP regulations requiring payment for urgently-needed care.)
• Must offer all Medicare covered services (Parts A & B). §417.414	• Same as risk. §417.414	• Not obligated to provide or arrange Part A. Need not offer all Part B, but at minimum must offer physician services, X rays, lab and other diagnostic tests. §417.800(d)
• HCFA must approve premiums. (This is the "adjusted community rate", or ACR, process).	• HCFA approves premiums.	• Same as for cost.
• May offer mandatory supplemental benefits in a basic package approved by HCFA. May also offer optional supplemental benefits. May charge a premium for both types of services.	• Must offer a "basic" package which is only Medicare-covered benefits. May also offer optional supplemental services.	• May provide mandatory supplemental services. Premiums for supplemental services are not required to be disclosed, but the entity may choose to do so.
• Basic premium charged covers actuarial value of Part A and B coinsurance and deductible and any mandatory supplemental benefits approved by HCFA. §417.454(a)(1)	• Basic premium covers actuarial value of Part A and B coinsurance and deductibles.	• Premium charged covers Part B coinsurance and deductible for in-plan services.

RISK CONTRACT	COST CONTRACT	HEALTH CARE PREPAYMENT PLAN
	3. Enrollment, Entitlement and Disenrollment	
• Must enroll any Medicare beneficiary entitled to Part A and Part B services or only Part B services. Exception is for beneficiaries with ESRD or who elected the hospice benefit. §417.420(a), 417.422	• Same as risk.	• May not impose any limitations on the acceptance of Medicare enrollees that it does not impose on non-Medicare individual enrollees. §417.801(b)(4) Can require beneficiary to have Part A.
• Members must live in HMO/CMP's risk contract service area. If member moves permanently from the service area or leaves for more than 90 days, plan must disenroll the member. §417.422(a)(2), 417.436(a)(4), 417.460(a)(2)	• Same as risk.	• No residency requirement.
• Cannot deny enrollment or disenroll on the basis of health status.	• Same as risk.	• May deny enrollment or disenroll if use same criteria as for non-Medicare enrollees.
• Must have annual open enrollment or period of at least 30 consecutive days for Medicare beneficiaries (may reserve vacancies if establish a waiting list). HCFA may waive open enrollment under certain conditions. §417.426	• Same as risk.	• No open enrollment requirements.
• At least 50% of members must not be Medicare or Medicaid beneficiaries. HCFA may waive under certain conditions, but only for public entities. §417.413(d)	• Same as risk.	• No limitations placed on percentage of Medicare and Medicaid beneficiaries.

RISK CONTRACT	COST CONTRACT	HEALTH CARE PREPAYMENT PLAN
	4. Financial Aspects	
• HMO/CMP financially at risk for expenditures exceeding the capitation rate. May retain same level of profit as on commercial accounts. §417.580 - 417.598	• Limited financial risk on Part A and B. Reimbursement is limited to what HCFA considers reasonable cost. No profit §417.530 - 417.568	• No financial risk on Part A. Limited financial risk on Part B, to what HCFA considers reasonable. No profit allowed. §417.800(c)(2),(d).
• HMO/CMP receives monthly prospective payments equal to 95% of the AAPCC as modified by demographic adjusters. §417.584, 417.588(c)	• HMO/CMP paid a monthly interim per capita on the basis of the organization's operating budget and enrollment forecasts. §417.570 -417.574	• Same as cost.
• No retroactive adjustments except for enrollment count. HMO/CMP Manual 5003-5004	• Annual settlement between organization and and HCFA based on HCFA's review of organization's cost report. HCFA determines total reimbursement due organization, compares with interim payments made and adjusts retroactively. §417.576	• Same as cost.
• HMO/CMP must pay hospitals and SNFs directly. OBRA'87 §4012	• May choose to pay some or all hospitals and SNFs directly or have HCFA pay directly. (Capitation is reduced under latter option). §417.532, 417.536	• HCFA pays all hospitals and SNFs (since Part A is not part of the HCPP contract).
• Not applicable.	• HMO/CMP must have procedures to check for duplicate HCFA payments (e.g., payments to provider by both fiscal intermediary or carrier, and by the HMO/CMP.	• Same as cost.
• Marketing costs may be included in ACR computation as "administrative and general" costs. §417.594(b)(3)(ix)	• Marketing costs are allowable as described in §417.538	• Marketing costs may be included in budget.
• Services provided directly by nurse practitioners, physician assistants, psychiatric social workers and clinical psychologists should be included as Medicare-covered items in ACR computation. §417.416(d)	• Services provided by nurse practitioners and physician assistants not under direct supervision of a physician may be included in the budget as Medicare-covered services. Services provided by psychiatric social workers and clinical psychologists may be included through June 30, 1990, only if under the supervision of a physician; direct physician supervision is not required as of July 1, 1990.	• Services provided by nurse practitioners and physician assistants are not reimbursable unless under the direct supervision of a physician. Services provided by psychiatric social workers and clinical psychologists is same as for cost.

RISK CONTRACT	COST CONTRACT	HEALTH CARE PREPAYMENT PLAN
	5. Oversight	
Quality Assurance		
• PRO/QRO reviews inpatient and ambulatory services. Must have an internal QA program. §417.418	• PRO reviews only inpatient services under fee-for-service regulations. HMO/CMP must have an internal QA program in place. §417.418	• No PRO review. QA program not required.
Marketing Materials		
• Marketing materials subject to prior HCFA review.	• Same as risk.	• No prior approval, but HCFA can require corrections later.
Grievances and Reconsiderations		
• Must have grievance system in place. §417.436(a)	• Same as risk. §417.436(a)	• No requirement.
• Medicare appeals process ("reconsiderations") must be in place. §417.604(b)	• Same as risk for all plans services covered under contract, including emergency services and out-of-area urgently needed services.	• No requirement.
Member Termination		
• HMO/CMP may terminate a member for cause, with HCFA's approval. §417.460	• Same as risk. §417.460	• No limitations.

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I. INTRODUCTION

New

Mr. Chairman and Members of the Subcommittee, I am pleased to be here to discuss innovation in the Medicare program. Bruce Vladeck, our Administrator, discussed this topic when he appeared before you in February. I am pleased to be able to report to you today on the progress we have made during the past months. While we are also in the process of making improvements in the fee-for-service portion of the Medicare program, I am going to focus today on our most recent activity in managed care. The Administration is committed to improving Medicare's managed care offerings. However, we are concerned about the danger of moving too quickly and strongly believe that we need to be cautious as we expand and improve the options for Medicare beneficiaries.

Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and nine percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care: we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from six to sixteen and in the Boston region contracts increased from four to nine.

As we work to extend and broaden managed care options for

Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population whose health care costs are lower. We have several efforts underway to improve the current payment methodology so it does not act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

II. NEW DIRECTIONS FOR MEDICARE MANAGED CARE

Medicare Choices Demonstration

Just two weeks ago HCFA announced "Medicare Choices," a new demonstration project designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies.

New

We are inviting a wide variety of managed care organizations to participate in this demonstration, including preferred provider organizations, health maintenance organizations and integrated delivery systems. Nine geographic areas have been targeted for the demonstration: Jacksonville, Florida; Sacramento, California; Hartford, Connecticut; Philadelphia, Pennsylvania; Atlanta, Georgia; New Orleans, Louisiana; Columbus, Ohio; Louisville, Kentucky; and Houston, Texas. We chose these markets to build on the strong base of private sector plans currently available in these communities. We will, however, accept applications from innovative plans in other areas, and we are particularly interested in those that offer to extend coverage to rural areas and those that emphasize primary care case management.

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Pre-application forms have already been distributed to many interested organizations. Based on the response to these initial letters, selected plans will be invited to submit more detailed final applications in the Fall. The demonstration is slated to begin in early 1996 and is expected to run for three to five years.

We are also soliciting support from Medicare contractors for the design of a competitive bidding demonstration and for the development of a marketing strategy to inform beneficiaries of the choices that they have in the Medicare program. In addition, we are actively pursuing studies on managed care issues, including the development of appropriate access measures for managed care plans.

Public-Private Partnership: Foundation for Accountability (FAcct)

HCFA, together with the Federal Employees Health Benefits Plan and the California Public Employees Retirement System, has joined private sector health purchasers in an unprecedented partnership to explore the formation of a new organization for quality improvement in the managed care industry. Private sector participants in this initiative -- called the Foundation for Accountability (FAcct) --include GTE, AT&T, and PepsiCo. The current membership of this group represent more than 80 million managed care enrollees. The intent of this new effort is to leverage the collective buying power of the participating organizations and to eliminate unnecessary duplication of individual accountability efforts that have nearly overwhelmed the managed care industry.

I am a co-chairman of the planning committee for FAcct and intend to be integrally involved in the development of this initiative. We expect to complement existing quality assurance organizations, such as the National Committee for Quality Assurance and the Joint Committee for the Accreditation of Health Organizations, and have received their support.

PPO Option

We want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. Medicare

SELECT plans have limited incentives to manage total costs. Under the PPO option, plans would be at some risk for Medicare benefits. Our objective is to ensure the same quality, access, grievance and appeal procedures as we do now in Medicare risk and cost plans. We hope to be able to work with the Subcommittee on the PPO option in the months ahead.

Beneficiary Education

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one-time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

III. QUALITY ASSURANCE AND IMPROVEMENT IN MANAGED CARE

When beneficiaries choose managed care, they are making a commitment to a set of providers, and they have the right to expect a commitment of adequate, high quality care in return. Unfortunately, Medicare's experience has shown that plans do not always follow through on their side of the bargain. When they fail to do so, it is the beneficiary who is hurt. I do not need to remind you that our beneficiaries are older and more vulnerable than the rest of the population.

Some plans with Medicare contracts have manipulated enrollment practices, withheld needed services, or delivered poor care. Florida provides a cautionary example: Humana and a number of other plans have been subject to investigations and other compliance actions in the last several years.

Based on recent experience, as well as advances in the marketplace, we anticipate continued, substantial growth in our managed care caseload, even absent changes in current law. We are keenly interested in assuring that as the Medicare managed care programs grow and evolve, we have adequate measures in place to assure and improve the quality of the care they provide.

Designing these measures is a challenge, as we must broaden

for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. HCFA has invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the Subcommittee on the structure of a competitive bidding demonstration.

IV. CONCLUSION

In conclusion, managed care will have an even more important role in Medicare's future than it has today. We are eager to improve the choices available to Medicare beneficiaries -- to make managed care plans more accessible, to help them work better, to pay them fairly, and to help insure that they provide health care of the highest quality. As we proceed, however, we must do so with caution. The industry must build capacity. We must create an environment in which beneficiaries can choose managed care, and choose freely in an informed fashion. Finally, we must assure beneficiaries that the care they commit themselves to is of high quality -- and we cannot assure quality without measurement and enforcement. We look forward to working with members of the Subcommittee in achieving these goals.

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enrollees in the HMO. The core measures included access to services, an annual influenza vaccination, and screening mammography for women.

We will pilot test some of the recommendations made by Delmarva within the coming months. The pilot will involve several PROs and their HMOs and will test mechanisms for analyzing data on the three core measures as well as measures developed for treatment of diabetes. Using this information, the participants will work cooperatively to develop projects to improve quality of care based on this analysis.

Along with information derived from a similar project underway in the fee-for-service sector (the Ambulatory Care Quality Improvement Project), HCFA expects to learn much about using performance measures to improve the quality of care for beneficiaries with diabetes. The lessons in outcomes measurement we will learn from projects like Delmarva, in combination with the results of our HEDIS efforts, will move us and the managed care industry down the road toward the uniform performance reporting system we all seek.

Coordination Activities

As I stated earlier, our performance measurement goals entail a long-term effort. Our over-arching goal is to work in partnership with the managed care industry, the states, the medical community and advocates alike to develop a single set of measures that gauge a health plan's performance. Our work on encounter data as the building blocks, HEDIS as the reporting template, and on Delmarva as a first attempt at examining compliance with performance measures, are early steps down the road to a performance measurement system that will enable managed care plans to continuously improve their quality of care and empower consumers to make responsible, informed choices.

As an example of this new partnership, HCFA is sponsoring an invitational forum to challenge both public and private entities to address the need for coordinated monitoring of managed care entities and other health care providers, to be held on April 19. We have invited stakeholders in this important industry; these include representatives of HCFA and the Public Health Service (PHS) involved as payers and regulators of managed care, state departments of health, insurance and Medicaid, HMOs, the managed care industry trade associations, accrediting organizations, employer associations, physician organizations involved in quality improvement, and consumers.

IV. PAYMENT ISSUES AND COMPETITIVE BIDDING

As I discussed above, concerns about the payment methodology

adapt HEDIS to the Medicare and Medicaid populations.

We are working jointly with the originator of HEDIS, the National Committee for Quality Assurance (NCQA), and with State Medicaid directors, consumers, provider groups, the United States Public Health Service, and the managed care industry on a Medicaid version of HEDIS. HCFA's goal is to adapt this promising commercial sector reporting tool to the needs of the Medicaid program and its beneficiaries. The Medicaid HEDIS project is funded by the David and Lucille Packard Foundation.

The Medicaid HEDIS project has twin objectives:

- First, by the end of 1995, produce a Medicaid-specific performance measurement set that we can provide to State Medicaid programs.

- Second, introduce Medicaid-relevant measures into the next version of HEDIS, version 3.0.

HCFA chose to use HEDIS as the template for our Medicaid effort because the managed care industry has used it for several years, and because the first step toward coordinated, quality care is uniform, consistent data. Furthermore, using HEDIS for Medicaid will build upon an established effective reporting system used by many large employers, while minimizing reporting burdens on our managed care plans.

While still on the drawing boards, HCFA also is designing a "Medicare HEDIS," with the support of the Kaiser Family Foundation. At present, HEDIS specifically excludes HMO enrollees who are age 65 or older. HCFA is working with the NCQA and others to develop a variety of measures for the Medicare population that will be incorporated into a future version of HEDIS. Medicare HEDIS will provide HCFA with a much broader array of vital and actionable information on health plan quality and value, and represents the template for our quality and performance measurement efforts.

The Delmarva Project

In 1993, HCFA contracted with the Delmarva Foundation (the PRO for Maryland) and Harvard University to work with a panel of quality assurance experts to develop a new methodology for external review. The Delmarva contract was intended to help HCFA and the PROs shift from the current mode of HMO oversight to one based on outcomes measurement and improving the quality of care. This project runs parallel to, and contributes to, our Medicare HEDIS effort.

Delmarva's report, released in August 1994, recommended three core performance measures that would apply to all Medicare

- and for plans, which will have the numbers to target resources and respond to the needs of diverse populations in Medicare and Medicaid.

The Oregon Scorecard Project, supported by AHCPR, should be helpful as we seek to develop meaningful quality indicators that beneficiaries can understand and use to make good choices regarding their health care.

Encounter Data

The building blocks of any future performance reporting system must be data on services provided by HMOs. While such data are readily available in the fee-for-service sector as a by-product of payment, many managed care plans do not currently have encounter data available due to the nature of prepayment. HCFA believes that adequate quality assurance activities require that managed care plans collect comparable data reflecting the key content of each patient encounter with a managed care provider. With comprehensive and comparable data, plans would be able to provide reports to purchasers addressing a range of purchaser needs.

HCFA is currently working in partnership with the managed care industry, States, and others in several important efforts to define encounter data standards for managed care plans. As the nation's largest managed care purchaser, we demand accountability and continuously improving outcomes from our contractors, just as any private purchaser would require. We recognize that plan collection of encounter data will, in many cases, be burdensome. However, without plan collection of encounter data, a quality improvement reporting system cannot be attained. As this will be a long-term undertaking, HCFA is making every effort to minimize the requirements we place on managed care plans for reports derived from this data. This is exemplified by one of our most exciting initiatives, our partnership with the industry on the Health Plan Employers Data and Information Set, or HEDIS.

Medicaid and Medicare HEDIS

With the rapid increase in the numbers of enrollees in managed care in the commercial sector, plans and employers began working together to develop a new HMO performance measurement tool. HEDIS is a core set of measures designed to help private sector firms gauge the value of the services provided by the firm's health plans. HEDIS includes data on a specified set of quality measures as well as measures of beneficiary satisfaction, financial indicators, and access to care. It is continually revised, with the third version expected next year. It will eventually permit consumers to compare the quality, value, and other merits of competing health plans. HCFA is now working to

- written procedures for taking appropriate actions to change areas needing improvement, and a process to determine the overall effectiveness of the program and individual action plans.

HCFA does not do business with managed care organizations unless they have these internal quality assessment and improvement programs in place prior to contracting; we follow-up with on-site reviews of our contractors every two years thereafter. In evaluating an HMO's quality assessment and improvement program, staff review the written plan and the resultant activities, and look for changes and improvements in the delivery of quality medical care. Further, HCFA looks at the involvement of a plan's board and top management in assessing the effectiveness of ongoing activities, specific actions and the overall program.

HCFA's enforcement authority is broad, from halting enrollment and marketing of non-compliant plans, to intermediate sanctions, to revocation of Federal Qualification and contracts with Medicare. Currently HCFA has three corrective actions underway with contractors, with a fourth investigation in progress, all of which are the result of quality of care deficiencies.

External Quality Assurance Programs

At this time, the PROs conduct HCFA's external quality assurance activities in Medicare risk-contracting HMOs. Since 1987, PRO review has consisted of review of (1) a sample of patient records, (2) a sample of Medicare enrollee deaths, and (3) all complaints PROs receive from Medicare HMO enrollees. If a pattern of quality problems is identified, an action plan is developed by the managed care plan in concert with the PRO. The PRO then monitors performance under the plan to ensure that the necessary improvements have been implemented.

However, HCFA, the PROs, and managed care plans believe that external review of HMOs must evolve into a uniform performance measurement system, rooted in a single set of measures that gauge a health plan's responsiveness to the needs of its membership. This represents a substantial undertaking, and entails a long-term effort we must begin now if we are to attain a seamless data and performance measurement system for quality care for all patients in all plans. HCFA, as the nation's largest managed care purchaser, must be the catalyst for this effort. Such a data system will bring accountability:

- for consumers, who will have the information they need to make informed, responsible choices;
- for providers, who will have the figures they need for continuous quality improvement and sensitivity;

our focus from facility-based care to the activities of an entire network of providers -- including physicians' offices. Further, unlike fee-for-service medicine, where each medical encounter results in a claim, information about particular services provided by managed care organizations is limited. We are facing up to this challenge and working closely with the managed care industry to develop appropriate and meaningful procedures that can be relied on by HCFA, by our beneficiaries, and by the managed care plans.

Internal Quality Assurance Programs

Quality of care efforts in managed care systems can be divided into (1) internal mechanisms, that is, each plan's own internal structure and activities for continuous improvement, and (2) external measurements, that is, performance measures imposed by external entities, for example, purchasers. Currently, Medicare risk HMOs must meet requirements for both internal and external quality review. In addition, we are exploring ways to improve external review programs, in partnership with managed care plans, commercial purchasers, and other interested parties and to maintain currency with state-of-the-art internal improvement processes.

The Medicare statute and regulations require all contracting plans to have an internal quality assessment and improvement program, which involves the following:

- an ongoing program with a written plan describing the structure, responsibilities, types of activities, and specific quality improvement projects for the coming year; a committee of practicing physicians and other representative practitioners with the commitment of adequate resources, including systems and staff; and board accountability for the program;

- an approach and activities stressing health outcomes which cover the entire range of care provided, and looks at the effects of provider compensation and incentives arrangements to assure that appropriate services are in fact provided;

- a systematic, iterative process to identify problems and areas for improvement, make appropriate changes; and monitor changes over time for effectiveness;

- peer review by physicians and other health professionals of the process of clinical care;

- systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners; and

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PROPOSED MEDICARE MANAGED CARE INITIATIVE

HHS's approach to expanding and improving Medicare managed care options involves four elements that are interrelated:

- Expanding the types of managed care options available to Medicare beneficiaries and the types of organizations offering managed care products;
- Improving the Average Adjusted Per Capita Costs (AAPCC) payment methodology and developing alternatives;
- Fostering continuous improvement in health plan quality; and
- Making Medicare beneficiaries more informed about managed care.

Our strategy is aimed at improving current options and offering new options through high-quality, private managed care plans that meet beneficiaries' needs and which are paid fairly.

EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS

Background - Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option (entities with risk or cost contracts and Medicare SELECT plans). This 9 percent figure does not include beneficiaries who have supplemental coverage through a managed care plan as retirees.

1994 was a year of impressive growth in Medicare managed care with double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

Although managed care in Medicare is strong and growing, we need to do more to expand options so that Medicare beneficiaries will have the same range of choices as are available to commercial enrollees.

Initiatives

- Preferred Provider Organizations. Legislation will be proposed to allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under this new authority include commercial PPOs that:

  - Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);

  - Share risk with an employer or other entity (other than its providers); and/or

  - Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

  Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

- Self-Referral Option. HHS is currently developing guidelines, under existing statutory authority, for current risk contractor to offer SRO with implementation anticipated by 1996. The SRO would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace. In contrast to the PPO option, the HMO-based SRO would be optional for both plans and enrollees. Plans would not have to offer such a benefit but if they did it would be as an optional benefit. Plans would have flexibility on the design of the SRO; however, all Medicare-covered services would have to continue to be available and accessible in-network for all enrollees.

- Integrated Delivery Systems. HHS is also planning to use its demonstration authority to explore the possibilities of contracting on a risk or partial risk basis with integrated delivery systems (e.g., hospital-physician organizations) that are not already HMOs or that could not meet the PPO requirements. Preliminary discussions are already underway with a number of such systems.

IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES

Background - The current payment methodology for risk contractors, the adjusted average per capita cost (AAPCC) methodology, is often viewed as a flawed methodology. There is no adjustment for health status, and payments vary from area to area in ways that do not reflect variation in HMO costs across areas. The rates are derived through a complex computation method that has been controversial in and of itself, but the methodology is not necessarily inaccurate in what it is intended to accomplish (which is to predict fee-for-service costs on a county-by-county basis).

For Medicare to benefit from an expansion of managed care, significant improvements are needed in the way that Medicare pays plans. Managed care currently costs the Medicare program rather than achieving savings. HHS evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that plans attract the healthier members of the Medicare population whose health care costs are lower and a workable health status adjustor is currently not available.

Initiatives

- Risk Adjusters. For the past decade, HHS has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should produce health status adjusters that can be used on a pilot or demonstration basis as early as 1996. HHS has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

- Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate using competitive pricing for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/61)

- Alternative Payment Demonstrations. HHS has entered into discussions with Kaiser to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be

adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees. In addition to this potential demonstration with Kaiser, HHS will soon issue a broad solicitation for demonstrations of alternative payment methodologies and risk sharing arrangements.

- o Partial Risk. Under another legislative proposal, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC.
  - + If total payments were less than the target, the plan would receive half of the difference.
  - + If total payments exceeded the target, the plan would receive half of that amount. However, Medicare payments could not exceed 100 percent of the AAPCC. (See HCFA-96/72)
- o AAPCC Technical Changes. Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology, e.g., MSA, rather than county-based, rates.

FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

Background - Monitoring quality of care for risk plans is especially important since capitation provides financial incentives to limit medical care. HHS monitors the quality of care provided by Medicare managed care plans through a variety of methods -- complaint monitoring, appeals monitoring, site visits, disenrollment data and external review by Peer Review Organizations (PROs).

PROs monitor quality by conducting medical record reviews for a sample of Medicare beneficiaries enrolled in the managed care plan. This approach can be confrontational and does not give plans insights into systemic problems in the delivery of care. It also does little to help guide them to make fundamental improvements in care.

Initiatives

- o Cooperative Improvement Projects. HHS is moving away from medical record review and towards the development of performance indicators and cooperative improvement projects between the PROs and risk plans.
- o Performance Indicators. For example, HHS plans to pilot

test a set of performance indicators developed by the Delmarva Foundation in several risk plans. Based on the performance indicators, the PRO and the risk plans will work cooperatively to develop an appropriate quality improvement plans. In a complimentary project, HHS also plans to begin collaborating with the National Committee on Quality Assurance (NCQA) to expand HEDIS to include performance indicators relevant to the Medicare population.

- o Encounter Data. Quality assurance systems utilizing performance indicators requires that managed care plans collect comparable, encounter data. However, due to the nature of capitation, most managed care plans do not collect this data. HHS plans to convene public and private purchasers of health care services and managed care plans to discuss issues regarding the collection of encounter data.

INFORMATION\ENROLLMENT

Currently, Medicare beneficiaries do not have the information needed to make an informed choice about available managed care and Medigap options. Even if information were available, comparisons are complicated by varying benefit packages in managed care plans and the use of different premium rating methodologies by Medigap insurers. Limited open enrollment for Medigap further complicates choices.

While Medigap insurers are only required to offer a one-time open enrollment period, Medicare managed care plans are required to offer an annual open enrollment period of at least 30 days to all Medicare beneficiaries living in the service area. As a result, beneficiaries who enroll in managed care plans (and stay enrolled through their Medigap open enrollment period) lose their opportunity to purchase the Medigap plan of their choice.

Initiatives

- o Consumer Information. As part of the competitive pricing demonstration described above HHS will be exploring how best to communicate to beneficiaries their available managed care and Medigap choices.

- o Level Playing Field. Under a legislative proposal, the current limited open enrollment for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)

	Federally Qualified HMO (FQHMO)	Competitive Medical Plan	Preferred Provider Organization
Self Referral Option (SRO)	Can be offered, at plan option, as an optional benefit May have some limitations based on FQHMO rules	Same as FQHMO Plan has complete discretion in regard to scope and design	Must be provided to all enrollees. Applies to all Medicare covered services. Cost-sharing for SRO services limited to Medicare cost-sharing
Risk Payment	No change for now	Same as FQHMO	Cost of SRO included in ACR. Actuarial value of cost-sharing in SRO included in determining maximum allowable premium.
Partial Risk Payment	New option - a base package provided to all enrollees includes: unlimited hospitalization, no 3-day prior requirement for SNF care and preventive benefits. Additional benefits offered at plan option.	Same as FQHMO	Same as FQHMO, except that SRO is included in base package. SRO limited to Medicare benefits, e.g does not include unlimited hospitalization etc.

Through legislative authority. HHS would implement competitive pricing demonstrations. Research efforts are directed toward developing and implementing health status adjustors. Demonstrations are both underway and under development to test other alternative payment methodologies and risk sharing arrangements.

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REMARKS:

Chris,

See my telephone messages. We assume you will get to OMB.

- Initiative

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

PRESCRIPTION DRUG BENEFIT IN MEDICARE RISK CONTRACTS

Proposal: Require plans with Medicare risk contracts to offer an outpatient prescription drug benefit (described below) either by itself or in combination with additional benefits. Plans that offer a drug benefit that meets or exceeds the standard benefit would be exempt from offering the standard benefit; plans that currently offer a benefit that is not actuarially equivalent to the standard benefit would be required to offer the standard benefit in addition to or in place of the lesser benefit.

Benefit: Initially, the drug benefit would be actuarially equivalent to the basic drug benefit in the Medigap standardized plans (Plan H and Plan I); this basic benefit has a $250 deductible, 50 percent co-insurance and a $1,250 cap. The actuarial equivalent would be indexed annually to drug spending in the elderly. Within this amount, plans would have the freedom to determine the co-payment structure and maximum dollar amount for the benefit. Plans would use co-payments and a dollar cap to define the benefit, rather than the co-insurance and deductible used in Medigap policies.

Financing: The benefit could be offered as an additional benefit financed by using savings from the AAPCC payment or as a supplemental benefit purchased by the beneficiary. If it were a supplemental benefit, plans could offer it as a stand alone or as part of a high option plan, subject to a requirement that guarantees it be offered at a reasonable price. Beneficiaries who exceed the cap will be able to continue to purchase drugs through the plan at 100 percent self-pay.

PROs:

- Approximately 47 percent of risk plans currently offer outpatient prescription drug coverage to Medicare enrollees.
- Provides an incentive for beneficiaries to enroll in managed care plans since medical underwriting and health screening make it difficult or impossible for many beneficiaries to purchase the Medigap plans that offer drug coverage.
- Managed care plans are usually able to offer a more cost-effective drug benefit due to negotiated prices with suppliers and the use of in-house pharmacies and mail order or bulk purchasing arrangements.

- HMOs frequently use generic drugs, utilization review (UR) and formularies to control expenditures. Good UR in a managed care program could reduce unnecessary hospitalizations due to medication errors.

- No additional cost to Federal government.

CONs:

- Could lead to adverse selection for plans and discourage their participation in the Medicare program.

- Could be perceived as overly regulatory.

- Makes a drug benefit available for beneficiaries enrolled in managed care, but does not offer financial assistance to assure access.

- Could lead to higher premiums in some cases.

PROPOSED MEDICARE MANAGED CARE INITIATIVE

HHS's approach to expanding and improving Medicare managed care options involves four elements that are interrelated:

- Expanding the types of managed care options available to Medicare beneficiaries and the types of organizations offering managed care products;
- Improving the Average Adjusted Per Capita Costs (AAPCC) payment methodology and developing alternatives;
- Fostering continuous improvement in health plan quality; and
- Making Medicare beneficiaries more informed about managed care.

Our strategy is aimed at improving current options and offering new options through high-quality, private managed care plans that meet beneficiaries' needs and which are paid fairly.

EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS

Background - Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option (entities with risk or cost contracts and Medicare SELECT plans). This 9 percent figure does not include beneficiaries who have supplemental coverage through a managed care plan as retirees.

1994 was a year of impressive growth in Medicare managed care with double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

Although managed care in Medicare is strong and growing, we need to do more to expand options so that Medicare beneficiaries will have the same range of choices as are available to commercial enrollees.

Initiatives

- Preferred Provider Organizations. Legislation will be proposed to allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under this new authority include commercial PPOs that:

  - Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);

  - Share risk with an employer or other entity (other than its providers); and/or

  - Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

  Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

- Self-Referral Option. HHS is currently developing guidelines, under existing statutory authority, for current risk contractors to offer a SRO with implementation anticipated for the 1996 contract year. The SRO would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace. In contrast to the PPO option, the HMO-based SRO would be optional for both plans and enrollees. Plans would not have to offer such a benefit but if they did it would be as an optional benefit. Plans would have flexibility on the design of the SRO; however, all Medicare-covered services would have to continue to be available and accessible in-network for all enrollees.

- Integrated Delivery Systems. HHS is also planning to use its demonstration authority to explore the possibilities of contracting on a risk or partial risk basis with integrated delivery systems (e.g., hospital-physician organizations) that are not already HMOs or that could not meet the PPO requirements. Preliminary discussions are already underway with a number of such systems. These integrated delivery systems could play an important role in bringing managed care to rural areas.

IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES

Background - The current payment methodology for risk contractors, the adjusted average per capita cost (AAPCC) methodology, is often viewed as a flawed methodology. There is no adjustment for health status, and payments vary from area to area in ways that do not reflect variation in HMO costs across areas. The rates are derived through a complex computation method that has been controversial in and of itself, but the methodology is not necessarily inaccurate in what it is intended to accomplish (which is to predict fee-for-service costs on a county-by-county basis).

For Medicare to benefit from an expansion of managed care, significant improvements are needed in the way that Medicare pays plans. Managed care currently costs the Medicare program rather than achieving savings. HHS evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that plans attract the healthier members of the Medicare population whose health care costs are lower and a workable health status adjustor is currently not available.

Initiatives

- Risk Adjusters. For the past decade, HHS has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should produce health status adjusters that can be used on a pilot or demonstration basis as early as 1996. HHS has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

- Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate competitive pricing as the basis for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/61)

- Alternative Payment Demonstrations. HHS has entered into discussions with Kaiser to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees. In addition to this potential demonstration with Kaiser, HHS will soon issue a broad solicitation for demonstrations of alternative payment methodologies and risk

sharing arrangements.

- Partial Risk. Under another legislative proposal, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC. Plans would share on a 50/50 basis in savings below 95 percent and costs between 95 and 105 percent. Plans would be responsible for all costs above 105 percent.

- AAPCC Technical Changes. Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology, e.g., MSA, rather than county-based, rates.

FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

Background - Monitoring quality of care for risk plans is especially important since capitation provides financial incentives to limit medical care. HHS monitors the quality of care provided by Medicare managed care plans through a variety of methods -- complaint monitoring, appeals monitoring, site visits, disenrollment data and external review by Peer Review Organizations (PROs).

PROs monitor quality by conducting medical record reviews for a sample of Medicare beneficiaries enrolled in the managed care plan. This approach can be confrontational and does not give plans insights into systemic problems in the delivery of care. It also does little to help guide them to make fundamental improvements in care.

Initiatives

- Cooperative Improvement Projects. HHS is moving away from medical record review and towards the development of performance indicators and cooperative improvement projects between the PROs and risk plans.

- Performance Indicators. For example, HHS plans to pilot test a set of performance indicators developed by the Delmarva Foundation in several risk plans. Based on the performance indicators, the PRO and the risk plans will work cooperatively to develop appropriate quality improvement plans. In a complementary project, HHS also plans to begin collaborating with the National Committee on Quality Assurance (NCQA) to expand the Health Plan Employer Data Information Set (HEDIS) to include performance indicators relevant to the Medicare population.

- Encounter Data. Quality assurance systems utilizing performance indicators require that managed care plans collect encounter data that is comparable across

plans. However, due to the nature of capitation, most managed care plans do not collect this data. HHS plans to convene public and private purchasers of health care services, consumer groups and managed care plans to discuss issues regarding the collection of encounter data.

INFORMATION\ENROLLMENT

Currently, Medicare beneficiaries do not have the information needed to make an informed choice about available managed care and Medigap options. Even if information were available, comparisons are complicated by varying benefit packages in managed care plans and the use of different premium rating methodologies by Medigap insurers. Limited open enrollment for Medigap further complicates choices.

While Medigap insurers are only required to offer a one-time open enrollment period, Medicare managed care plans are required to offer an annual open enrollment period of at least 30 days to all Medicare beneficiaries living in the service area. As a result, beneficiaries who enroll in managed care plans (and stay enrolled through their Medigap open enrollment period) lose their opportunity to purchase the Medigap plan of their choice.

Initiatives

- Consumer Information. As part of the competitive pricing demonstration described above, HHS will be exploring how best to communicate comparative information to beneficiaries regarding their managed care and Medigap choices.

- Level Playing Field. Under a legislative proposal, the current limited open enrollment for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)

- 50/50 Flexibility. HHS would seek legislative authority to waive the 50/50 rule for plans responding to state initiatives to enroll Medicaid beneficiaries in managed care plans and for plans expanding into rural areas. (See HCFA-96/69)

HCFA-96/71

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Medicare PPO Option

Expand the Types of Managed Care Entities That Can Contract to Enroll Medicare Beneficiaries to Include PPOs and Other Entities; Define Base Benefit Package to Include a Comprehensive Self-Referral Option

Current Law: Federally qualified HMOs and entities meeting the requirements to qualify as a competitive medical plan (CMP) can contract with Medicare on either a risk or cost basis to provide the Medicare benefit package to plan enrollees. They must provide all Medicare Part A and Part B services available in their geographic area.

In order for HMOs and CMPs to be eligible to contract with Medicare, they must either be a Federally Qualified HMO or meet certain criteria related to their commercial business. Among these criteria, the entity must:

- provide physician services exclusively or primarily (defined as at least 51 percent) through physicians who are the plan's employees or partners, or who are under contract with the plan, (except for unusual and emergency services); and
- assume full financial risk on a prospective basis for the provision of health care services.

Many preferred provider organizations (PPOs) and insurers cannot meet these requirements.

Contracting HMOs and CMPs can opt to be paid on either a full risk or cost basis. These two payment arrangements have specific implications for plan enrollees in regard to how they receive their care:

- Cost plan enrollees are not locked in, i.e., if they choose to obtain out-of-plan services, Medicare pays its established payment and the cost plan enrollee is responsible for any Medicare cost sharing, e.g., 20 percent coinsurance for physician services.
- Risk enrollees are locked in; if they choose to obtain out-of-plan services, they are responsible for payment of the full charges for those services (other than for emergency services).

Entities with risk contracts do have an option of providing an alternative to a strict lock-in through the use of a self-referral option (SRO). Under an SRO, an enrollee has the option

of going out-of-plan for some subset of services and receiving partial payment from the HMO or CMP. Plans have flexibility in the design of SROs, but they can only be offered as an optional supplemental benefit.

Proposal: Allow (1) preferred provider organizations; (2) licensed insurance companies; and (3) prepaid hospital or medical service plans that meet the following criteria to contract with Medicare on a full or partial risk basis as "preferred provider organizations" or PPOs.

The contracting organization must:

- be in the business of providing a plan of health insurance or health benefits, and be organized under the laws of any State.
- provide physicians' services directly (1) through physicians who are either employees or partners of such an organization or (2) through contracts or agreements with individual physicians or one or more groups of physicians.
- have made adequate provision, satisfactory to the Secretary, against the risk of insolvency (see §1876(b)(2)(E)).
- have effective procedures, satisfactory to the Secretary, to monitor utilization and to control the cost of services.

In addition to the current requirement to offer all Medicare-covered benefits available in the geographic area, these PPOs would be required to provide Medicare enrollees a comprehensive SRO. Under this benefit, enrollees would have the option of obtaining any and all Medicare-covered benefits through a non-network provider. Cost sharing for non-network services could not exceed the Medicare deductibles and coinsurance amounts charged in traditional fee-for-service Medicare.

PPOs contracting on a full risk basis would include the cost of the comprehensive SRO with the cost of Medicare benefits when computing the adjusted community rate (ACR). All PPOs would include the actuarial value of cost-sharing under the SRO, in addition to the actuarial value of in-network cost-sharing, in determining the maximum amount allowed for the plan premium.

Requirements for an ongoing quality assurance program, availability and accessibility standards, enrollment standards, grievance and appeals requirements, review of marketing material, minimum commercial enrollee base, 50/50 enrollment requirement and intermediate sanctions and civil monetary penalties would be the same as those that apply to HMOs and CMPs.

Rationale: When the Medicare HMO/CMP provisions were enacted in 1982, only two options for health care coverage were available in the commercial sector: (1) fee-for-service plans or (2) lock-in

(i.e., no coverage for any out-of-plan services) health maintenance organizations. Subsequently, hybrids of fee-for-service and lock-in HMOs were developed. They allow individuals and payers to obtain some of the cost and quality benefits of a managed care system, while also providing enrollees with the option of obtaining reimbursement for out-of-plan services. These hybrids go by several names, e.g., point of service options, preferred provider organizations, self-referral options, and out-of-network options.

Since they first became widely available, these options have become very popular with commercial enrollees, accounting for much of the dramatic growth in commercial managed care enrollment. This proposal would make a hybrid option available to Medicare beneficiaries. Under this proposal, beneficiaries would be able to receive the benefits of managed care, but they would also have the option of receiving coverage if they go out-of-plan to receive services. It would also expand the number and types of managed care plans available to Medicare beneficiaries.

Effect on Beneficiaries: This proposal would make a comprehensive self-referral option available to Medicare beneficiaries, giving them more choices similar to those available in the commercial sector.

Cost: None.

Effective Date: January 1, 1997.

HCFA-96/61

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Medicare HMO Competitive Pricing Demonstration

Permit a Medicare HMO Competitive Rate Setting Demonstration

Current Law: Medicare pays health maintenance organizations (HMOs) and competitive medical plans (CMPs) with risk contracts 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is Medicare's estimate, for each calendar year, of what the average cost per beneficiary would have been in the fee-for-service system in a specific county; this is the base rate. The base rate is then adjusted by demographic characteristics of Medicare beneficiaries; i.e., age, sex, institutional status, and Medicaid status. There is no adjustment for an individual's health status. HMOs may also enter into cost-reimbursement contracts with Medicare.

If a risk HMO's expected revenue from AAPCC payments exceeds the revenue needs of the HMO for providing Medicare covered services (including the same level of profit the HMO generates in the commercial market), the HMO must either accept a reduced government payment or return the "savings" to beneficiaries by reducing beneficiary charges or providing non-covered services.

Proposal: Permit the Secretary to conduct a demonstration under which rates paid to Medicare HMOs would be established using a competitive pricing methodology, including, but not limited to, a method that bases Medicare rates on the commercial, competitively determined rates of plans. Plans would compete in the context of a coordinated open enrollment process and would bid using a standard basic benefit package. In its offering to beneficiaries, a plan would be required to adhere to the premium structure included in its bid.

All HMOs in demonstration areas that want to continue to serve Medicare beneficiaries would either have to participate in the competitive pricing demonstration or would receive payment under Medicare fee-for-service rules (including through Medicare SELECT, if available). There would be no other option available to HMOs in such areas. Total payments across demonstration sites would be subject to a payment limit of 95 percent of the AAPCC, although payments to individual areas could exceed 95 percent of the AAPCC. The government contribution in an individual geographic area would be limited to 100 percent of the AAPCC. To prevent drastic increases in premiums as a result of the demonstration, the Secretary would develop special transition rules in market areas where risk plan enrollees currently pay small or no premiums .

Other managed care options, such as preferred provider

organizations and integrated delivery systems, might be eligible to participate in the competitive pricing process. Employer-based or union-based plans for retirees might also be included.

HCFA would develop details of the competitive pricing process, such as what type of health status adjuster to use; the minimum number of bidders; and the criteria for selecting geographic areas. It is anticipated that the geographic areas would include both relatively high and low payment areas and areas with both relatively high and low market penetration.

Rationale: Under the current payment methodology, the government determines rates on a yearly basis, and the HMOs decide, based on those rates, whether they wish to enter into contracts with Medicare. The established rates are based on historical fee-for-service costs in a given county, and the payment rates can vary significantly from year to year and from county to county. The AAPCC payments do not appear always to reflect the expected cost to a managed care organization of providing medically appropriate care to Medicare beneficiaries. For example, the 1995 monthly rates in Miami area are in the $550 to $600 range. Plans in Miami charge no premiums, and offer generous additional benefits at no cost. In contrast, the rates in Minneapolis are in the $360 to $380 range; plans must charge about $150 a month to offer a benefit package comparable to what is available to beneficiaries in the Miami area.

This disparity in AAPCC rates has been a constant source of criticism, particularly from plans on the low end of the payment scale and from beneficiaries who reside in their service areas, as well as from many observers who find such wide disparities disconcerting. (This disparity is addressed by creating ceilings and floors on Part B AAPCC rates, see HCFA-96/66.) While the current methodology, which derives the base payment rate from Medicare's fee-for-service costs, is subject to criticism, there are very few options for changing it. One that has received a great deal of attention from the HMO industry, from academics, and from commercial payers is competitive pricing. A competitive pricing methodology should result in rates that more accurately reflect the true costs of doing business, and competitive pricing should promote efficiency through greater competition among health plans.

In a competitive pricing model, competition among health plans would establish the premiums in a given area (the premium being the government contribution, replacing the AAPCC, plus beneficiary liability amounts). Plans would "bid" on Medicare-covered services (i.e., offer to provide a defined set of services for a set premium), and a fixed Medicare contribution would be established through the bidding mechanism. Alternatively, the plan premium could be based on the level of premiums the HMO charges in the commercial sector multiplied by a Medicare utilization factor.

There would not be a winner-take-all approach, in that high-bid HMOs would be allowed to participate and charge higher premiums to Medicare beneficiaries (based on their bid having exceeded the level of the government contribution). With plans offering a standard benefit package, competition among the plans for the Medicare population would be based on price and known or perceived quality (e.g., higher-cost plans might offer a greater range of providers or might include providers that are highly regarded in the community). There would also be a risk adjustment methodology to ensure that price differentials among HMOs do not reflect a healthier mix of enrollees in one or more HMOs.

The proposed demonstration would be mandatory because any change to the AAPCC methodology would create winners and losers relative to the status quo, and it would be difficult to develop consensus on changing the rate setting methodology. Since any HCFA demonstrations of competitive pricing would create winners and losers, voluntary demonstrations would not allow us to adequately demonstrate such a change because only plans that believe they would benefit (those in relatively low payment areas) would choose to participate. HCFA needs to require appropriate areas to participate in a demonstration to adequately study whether this approach to ratesetting merits program-wide implementation.

Designing a demonstration of competitive pricing would require a significant investment of time because of the many complex, interrelated issues that would have to be addressed. It is not appropriate to invest the time needed to design such a demonstration unless plans in certain areas can be required to participate, and such a demonstration would not have merit if it did not involve all plans in a defined geographic area.

Effect on Beneficiaries: Beneficiaries in areas with high payments under the AAPCC method might have higher premium costs than they do now. Conversely, beneficiaries in lower payment areas might have lower individual premiums if Medicare's payments exceed 95 percent of the AAPCC. A more equitable payment system might ultimately encourage more plans to contract with Medicare, making the HMO option more widely available to our beneficiaries.

Cost: None.

Effective Date: January 1, 1997.

HCFA-96/72

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Partial Risk Payment Option

Create a Partial Risk Payment Methodology for Managed Care Entities

Current Law: Under Section 1876 of the Social Security Act, Federally qualified HMOs and entities meeting the requirements to qualify as a competitive medical plan (CMP) can contract with Medicare on either a risk or cost basis to provide the Medicare benefit package to plan enrollees. Under Section 1833(a)(1)(A), plans can enter into agreements with the Medicare program to provide or arrange for Part B medical and other health services on a prepayment basis. Two types of organizations enter such agreements: (1) commercial health maintenance organizations (HMOs) and (2) union- or employer-sponsored prepaid health plans. HCFA regulations refer to these organizations as "health care prepayment plans (HCPPs)."

Except for requirements about beneficiary cost-sharing liability, §1833(a)(1)(A) does not impose requirements for beneficiary or program safeguards on HCPPs. For example, there are no requirements that: prohibit health screening; require review of marketing material; provide assurances about the availability and accessibility of services within a defined service area; offer a process for enrollee grievances; or assure fiscal solvency. In addition, HCFA has almost no recourse if an HCPP performs poorly, whereas section 1876 contracts can be terminated or civil monetary penalties imposed if requirements are not met.
As a result of a provision in the Social Security Amendments of 1994, HCPPs will be treated as Medigap products as of January 1, 1996. Although employer- or union-sponsored plans are not affected by this requirement, other HCPPs would be unable to meet Medigap requirements such as the requirement for standard benefit packages.

HMOs and CMPs electing risk payment under section 1876 receive a predetermined monthly per capita payment based on 95 percent of Medicare's projected adjusted average per capita cost (AAPCC) for beneficiaries who are not enrolled in HMOs, i.e., they are in fee-for-service Medicare. Risk plans can obtain private reinsurance, but from the Medicare program's perspective, they are at full risk for the cost of services to enrollees. That is, they can keep any difference between their costs and their Medicare payments. Similarly, they are liable for any losses they sustain if Medicare payments do not cover their costs.

Payment to an entity electing a cost contract under section 1876 or an HCPP agreement under section 1833 is similar. Under both arrangements, the entity receives interim payments, subject to

annual reconciliation of the cost report. Although in theory Medicare receives the full benefit from these managed care arrangements, plans have little incentive to be efficient because they are reimbursed for the costs that they document, subject to general provisions about reasonableness of costs. Sometimes they receive payments substantially in excess of 100 percent of the AAPCC.

Under current law, there is no partial risk payment methodology.

Proposal: Create a new partial risk payment option for managed care plans that contract with Medicare. Under this option, the entity would be paid for services provided to plan enrollees on a fee-for-service basis using Medicare payment rates, minus a five percent withhold. The entity would then pay providers and suppliers based on its negotiated rates.

At the end of the year, total Medicare payments plus the withhold would be compared to a target (initially established at 95 percent of the Adjusted Average Per Capita Cost (AAPCC)).

- If this total were less than the target, the plan would receive the full withhold plus a bonus payment equal to 50 percent of the difference between the total Medicare payments (plus the withhold) and the target.

- If the total were greater than the target but less than 105 percent of the AAPCC, the plan would have to forfeit that portion of the withhold equal to 50 percent of the amount by which the target was exceeded.

- Finally, if the total exceeded 105 percent of the AAPCC, Medicare would not share in any cost above 105 percent. If this happened in two consecutive years, the contract with the entity would not be renewed.

Unlike the full risk methodology, entities would not be required to submit Adjusted Community Rates (ACRs) or provide any additional benefits beyond the base benefit package. This package would include Medicare benefits, unlimited hospitalization, SNF services without a prior hospitalization requirement, and preventive services (for PPOs, the base package would also include a comprehensive SRO, however, the SRO would be limited to Medicare benefits (i.e., would not include unlimited hospitalization, etc.)). Plans would be free to offer additional benefits beyond the base benefit package.

As with the full risk option, the plan premium plus the actuarial value of cost-sharing for the base benefit package could not exceed the actuarial value of Medicare deductibles and coinsurance.

Requirements for an ongoing quality assurance program, availability and accessibility standards, enrollment standards,

grievance and appeals requirements, review of marketing material, 50/50 requirement, intermediate sanctions and CMPs would be the same as applies to risk contractors. Entities would be required to have 1,500 commercial enrollees in order to contract on a partial risk basis (5,000 enrollees are required for full risk). They would also have to demonstrate that they had adequate reinsurance to protect against the possibility of losses above 105 percent of the AAPCC.

For purposes of computing the AAPCC, enrollees in plans under the partial risk arrangement would be treated as fee-for-service beneficiaries.

The current HCPP option would be eliminated for managed care plans (entities that provide or arrange for inpatient hospital services in addition to Part B services, excluding union and employer sponsored plans), effective January 1, 1997. HCFA would provide oversight of the remaining HCPPs (with appropriate provisions of section 1876 being applied to these entities) and coverage of HCPPs under the Medigap definition would be repealed.

Except for HCPPs converting to section 1876 cost contracts, no new cost contracts would be entered into after January 1, 1996. The partial risk option would be available starting January 1, 1997. The cost option would be eliminated January 1, 2001.

Rationale: Some prepaid plans that contract with Medicare choose the cost contracting or HCPP options. However, Medicare costs for these entities often exceed 100 percent of the AAPCC, which means that Medicare pays more for these enrollees than it would have if they had stayed in fee-for-service Medicare. Further, preparation of cost reports and auditing of cost reports is a long and time-consuming process for both the plans and HCFA staff. In addition, since the early 1980s, partial risk payment arrangements in the commercial sector have become popular.

If cost plans are reluctant to assume full risk, a partial risk option should alleviate some of their concerns, while providing necessary incentives to manage care more effectively than they do currently. In addition, plans that have rejected both the cost and full risk options may choose to contract on a partial risk basis, particularly entities that conduct their commercial business on a partial risk basis.

The proposed partial risk payment methodology would provide HCFA with full utilization information and, to the extent that plans are successful in reducing unnecessary utilization, would have a restraining effect on the AAPCC in the area. Plans could use savings from discount arrangements and their share of the utilization savings to establish premiums substantially below those of traditional Medigap policies. Unlike the full risk methodology, plans would receive only half of any benefit resulting from favorable selection. It is assumed that the partial risk option would normally lead to the assumption of full

risk.

Effect on Beneficiaries: Assuming that more managed care entities would choose to contract with Medicare if a partial risk option were available, this proposal would make more managed care options available for beneficiaries.

Cost: None.

Effective Date: January 1, 1997.

HCFA-96/70

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Establish Annual 30-Day Open Enrollment for Medigap Policies

Current Law: Medigap insurers are required to have a six-month open enrollment period for Medicare beneficiaries that starts when they enroll in Part B and turn age 65. Outside of this one-time window, insurers may use health screening and medical underwriting to either exclude beneficiaries on the basis of health status or adjust premiums on the basis of past or potential use of services. During the open enrollment period, and at any other time, insurers can apply a six-month waiting period for benefits related to the treatment of a condition treated or diagnosed in the six months prior to the purchase of a policy.

Medicare SELECT polices are subject to the same enrollment provisions as are regular Medigap policies. However, SELECT insurers must make available, at the beneficiary's request and without further evidence of insurability, any non-SELECT policies that they otherwise offer that contain comparable or fewer benefits than the SELECT policy.

Managed care plans with risk or cost contracts with Medicare are required to have an annual thirty-day open enrollment period for all beneficiaries living in the service area. Plans are not permitted to health screen, impose pre-existing condition limitations or charge different premiums on the basis of health status.

Proposal: Require Medigap insurers to offer policies as guaranteed issue to all Medicare beneficiaries during an annual 30-day period, the timing of which is at the insurer's discretion.

Rationale: Health screening and medical underwriting can make it impossible for beneficiaries to obtain the Medigap policy of their choice after their one-time open enrollment period has ended. This discourages some beneficiaries from choosing to enroll in risk contracts or Medicare SELECT because they waive their open enrollment opportunity if they stay in the selected managed care option for longer than six months. In some cases, beneficiaries may purchase and carry an unnecessary Medigap policy as a safeguard in the event that they disenroll from managed care. Requiring Medigap insurers to offer an annual open enrollment period could eliminate these problems, which would increase the likelihood that beneficiaries would choose a managed care option. It would also benefit individuals who wish to change (e.g., upgrade) their level of coverage in a regular Medigap policy or switch from a policy that is attained-age rated or otherwise undesirable.

Effect on Beneficiaries: An annual open enrollment period for Medigap policies would remove a barrier to participation in managed care and ensure the availability of choices for beneficiaries purchasing Medigap policies.

Cost: None.

Effective Date: January 1, 1996.

HCFA-96/69

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Permit Exceptions to Enrollment Requirement

Current Law: The combined enrollment of Medicare beneficiaries and Medicaid recipients may not exceed 50 percent of total enrollment for Medicare-contracting HMOs and CMPs (50/50 rule). Presently, waivers are permitted in two circumstances: (1) for contracting organizations in areas where the proportion of Medicare and/or Medicaid eligibles exceeds 50 percent of the area's population, and (2) for publicly owned or operated contracting organizations for a period of three years as long as the entity is making an effort to enroll commercial members.

Proposal: Permit waivers or modifications of the 50/50 rule for Medicare contracting HMOs/CMPs that (1) have a substantial Medicare enrollment in a State and wish to participate in the State's Medicaid managed care program or (2) would like to contract to serve a rural area. The Secretary would determine the factors and conditions that warrant a waiver, such as the level of managed care penetration and competition for commercial enrollment in an area, commercial enrollment trends, and demographics and other population characteristics. To qualify for the waiver, the following standards would be required. The HMO/CMP:

a. has contracted with HCFA and continuously served Medicare enrollees in the State for at least the previous three years;

b. has demonstrated, during the last three years, compliance with program requirements for quality, access, marketing, health services delivery, enrollment (including 50/50), and fiscal soundness;

c. complies with additional quality monitoring and reporting requirements specified by HCFA, including collection and reporting of 100 percent encounter data;

d. assures that appeal and grievance procedures meet Medicare and Medicaid requirements; and

e. meets a minimum commercial enrollment requirement established by the Secretary and continues to make a reasonable effort to enroll commercial members.

Where the health plan is participating in a Medicaid managed care initiative, the HMO or CMP would be required to meet the 75/25 enrollment requirement set forth in §1903(m). If a health plan is participating in a Medicaid managed care program in a State with §1115 waiver authority and the State is exercising its

option to waive the 75/25 requirement, then the HMO or CMP would be waived from meeting an enrollment requirement. In the latter case, HCFA could implement additional monitoring activities/requirements deemed necessary.

Rationale: A number of HCFA's contracting health plans committed to serving the senior population also wish to participate in State Medicaid managed care initiatives. However, participation in these State initiatives might jeopardize the plan's ability to enroll seniors, or continue to contract with HCFA, because of the 50/50 rule. For example, a Federally qualified HMO serving the greater Philadelphia area currently has over 10,000 Medicare enrollees in a risk contract and serves over 35,000 Medicaid enrollees under Pennsylvania's HealthPASS program; commercial enrollment is 50,000. The State is implementing a new program, HealthCHOICES, which will expand managed care from 250,000 to 650,000 Medicaid eligibles by mid-1995 in the greater Philadelphia area. Due to competition from five existing HMOs (including two very large, aggressive plans) in this urban area and six additional "newcomers" entering the market next year, this HMO does not anticipate commercial growth to keep pace with new Medicaid enrollment. Thus, in order to participate in the state's HealthCHOICES initiative, this HMO might be forced to drop its senior plan because of the 50/50 rule.

Additional Medicare contractors, depending on the §1115 and §1915(b) waiver authorities granted to the State, anticipate problems in the near future.

Further, several HMOs have exhibited an interest in serving rural areas and have listed the 50/50 rule among their concerns or barriers. Often, rural populations have high proportions of seniors, and younger residents are often uninsured, thus creating an imbalance in the population's characteristics for meeting this enrollment standard. One Catholic-owned health care chain, which has as part of its mission to enter rural areas and provide care to the underserved, has established an HMO to serve a rural county in Oregon with the cooperation of a local medical center and its managed care-experienced administrator. With active marketing, the health plan has been able to enroll 3,550 commercial members and 1,850 Medicare beneficiaries, but the plan anticipates more growth among seniors. The plan may be in violation of the 50/50 rule by the 1996 contract year and enforcement will require termination of this health plan which is otherwise in good standing. Such an action would deter this nonprofit corporation and other organizations from bringing low-cost, managed health care to other rural areas. The current Medicare enrollees would lose expanded benefits, including preventive services, coordination of care, and lower health expenditures.

Effect on Beneficiaries: This proposal would remove an artificial barrier to the availability of managed care and ensure Medicare beneficiaries, including those residing in rural areas,

more choice in obtaining health care. In the absence of this change, it is likely that local managed health plans will close or not open enrollment to seniors.

Cost: To be determined.

Effective Date: Upon enactment.