

SUNSETTED



***ACP policy originating from ACP sponsored resolution introduced to the AMA House of Delegates**

MANAGED CARE

Physician Privileging

The ACP supports that one standard credentialing and re-credentialing form be used for healthcare plans and hospitals, and that practicing physicians should be involved in the development of the form. (BoR 00, reaffirmed 11)

Patient Protection Legislation

ACP believes that any effective patient protection legislation must:

- Apply to all insured Americans, not just those in ERISA plans.
- Require that physicians, rather than health plans, make determinations regarding the medical necessity and appropriateness of treatments. ACP supports language that defines medical necessity in terms of generally accepted principles of professional medical practice, as supported by evidence on the effectiveness of different treatments when available.
- Provide enrollees with timely access to a review process with an opportunity for independent review by an independent physician when a service is denied.
- Offer all enrollees in managed care plans a point-of-service option that will enable them to obtain care from physicians outside the health plan's network of participating health professionals, and
- Hold all health plans, including those exempt from state regulation under ERISA, accountable in a court of law for medical decisions that result in death or injury to a patient. (BoR 2-99, reaffirmed BoR 10)

Medical/Surgical and Psychiatric Service Integration and Reimbursement

The American College of Physicians (ACP) advocates for health care policies that insure access to and reimbursement for integrated medical and psychiatric care regardless of the clinical setting.

ACP advocates for standards that encourage medically necessary treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. (BoR 99, reaffirmed 11)

Appealing Managed Care Plans' Denials of Medical Care

The American College of Physicians takes an active role in encouraging the enactment of Federal laws and regulations that mandate:

1. That decisions regarding coverage that cannot be resolved by the managed care plan on the first telephone call from a physician's office must be decided promptly by a managed care plan physician, and that to do this, Managed care plans be required to have 24 hours telephone access for physician-to-physician dialogue with the ability to resolve any clinical or medical necessity issues;

2. That the managed care plan physician ultimately denying medical necessity decisions needs to be licensed in the state in which the patient is being treated and needs to be in a specialty relevant to the medical problem;
3. That an appeal of the managed care plan physician's decision needs to be heard by the managed care plan Medical Director in a time frame as determined by the urgency of the medical condition;
4. That a managed care plan will be prevented from retrospectively denying payment for services if prior approval had been obtained and the information provided by the physician was accurate. (BoR 98, revised BoR 10)

Patient Choice of Health Plans and Physicians

1. Patients must have a choice of health plans and the opportunity to voluntarily choose plans that best meet their health needs.
2. Patients should not be "locked-in" to receiving care from any one physician for an indefinite period of time but allowed the freedom to select another physician as their patient care manager if and when they choose.
3. Patients must be clearly informed in advance of any restrictions on their access to specialists that may result from their choice of alternative delivery systems. (HoD 86; reaffirmed BoR 04)*

Internists' Role in a Managed Care Setting

1. ACP supports the role of internists in providing services to patients in a managed care setting. Managed care policy and reimbursement methods should promote proper recognition of both primary care services and consultative services. (HoD 93; reaffirmed BoR 04)*
2. Physicians are best suited for the role of patient care manager. The internist is an important and highly qualified component of the patient care manager system. Physicians who assume the case manager function must possess broad clinical competence and appropriate training in primary care. The physicians providing case management services should be appropriately reimbursed for performing the additional management/administrative functions associated with this role. (HoD 86; reaffirmed BoR 04)*
3. ACP supports scope of practice legislation or designation by managed care organizations that are consistent with ACP policy that focuses on physicians' training and expertise rather than legislative mandates or managed care policies that specifically name medical specialties as primary care physicians. (HoD 95; reaffirmed BoR 08)*

Expanding Access to Internists and Internal Medicine Subspecialists

Managed care plans should permit expanded patient access to internists and internal medicine subspecialists by:

1. Giving internal medicine subspecialists and generalists the same opportunities to participate as primary care/~~gate-keeper~~ physicians for any enrolled patient who wishes to choose them, provided that they meet the same or equivalent credentialing criteria--such as demonstrated competence in all aspects of primary care.
2. Permitting internal medicine subspecialists to participate with managed care plans as primary care physicians, principal care physicians and/or consultants based on their preference if they meet the requisite credentialing criteria for each role.
3. Allowing internal medicine subspecialists listed as consultants with a health plan to act as principal care physicians for patients with conditions in their area of expertise. Health plans should consult with representatives of the internal medicine subspecialties on specific disease conditions that would qualify for principal care. Plans should not require patients to obtain

authorization from a gatekeeper physician to receive services from their principal care physician

4. Health plans should evaluate the cost of subspecialist and primary care physicians by using severity-adjusted economic profiles and other measures of physician performance, rather than arbitrarily limiting subspecialists' scope of practice because of cost-effectiveness concerns. (Reinventing Managed Care: Patient Access to Internist-Subspecialists in Gatekeeper Health Plans, ASIM 95; reaffirmed BoR 08)

Definition of Principal Care Services

Principal care, that is, the predominant source of care for a patient based on his or her needs, can be provided by a primary care physician or medical specialist. In most cases, primary care physicians, with their office care team, are ideally suited to provide principal care and be a patient's care coordinator – a personal physician, in the advanced medical home model. However, a medical specialist with his or her office care team can fulfill the role of personal physician as defined in this paper if he or she so chooses. (The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care BoR 06)

Definition of Primary Care Services

ACP supports the Institute of Medicine definition of primary care as revised: the provision of integrated, accessible health care services by physicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. ACP defines the minimum set of medical services a physician must provide to be designated as a primary care physician as follows:

1. Provision of comprehensive care that is not organ- or disease-specific;
2. Periodic health maintenance exams;
3. Health counseling;
4. Ability to provide preventive services, such as immunizations and cancer screening;
5. Ability to provide terminal care;
6. Comprehensive disease management;
7. Coordination of continuum of care for acute and chronic illnesses;
8. Arrangement of consultations when appropriate;
9. Ability to provide emergent care as it presents itself in the office setting, and arrange for definitive care in a separate designated urgent care facility as necessary. (HoD 96; reaffirmed BoR 08)*

Physician Credentialing

1. In consultation with practicing physicians, Managed care plans should develop a uniform, standardized credentialing process for collecting and verifying documents--including applications and credentialing questionnaires--for managed care products. Managed care and other entities should adopt these standardized credentialing materials and a uniform credentialing process.
2. Each managed care plan should evaluate the professional competence of physician applicants and panel members in a manner that is comprehensive, but not cumbersome or inordinately time consuming.
3. Managed care plans should assess physicians on the basis of education, training, experience and demonstrated competence.
4. Managed care plans should use nationally recognized guidelines for procedural competence in assessing physicians.

5. Managed care plans should provide a fair hearing and an appeals process for applicants or panel members who have been denied participation or retention for reasons related to professional competency.
6. Each physician should have to complete the credentialing document collection process only once; other Managed care plans or contractors can share the results, with the physician's consent. Similarly, physicians should complete recredentialing documents only once every two years; other Managed care plans or contractors can share the results, with the physician's consent.
7. Physicians should have to fill out the uniform credentialing application only once. Recredentialing applications should contain a summary of the information in the credentialing file for the physician to review, verify and change as necessary.
8. Physicians who change practice location or affiliation should not have to undergo automatic recredentialing.
9. Managed care plans should recognize the services provided by any qualified *locum tenens* physician covering for physicians already on the health plan's panel, for a specified, reasonable maximum number of days per year (determined on a case-specific basis). The health plan should base payment to the covering physician on its accepted schedules or arrangements. (Reinventing Managed Care: Reducing the Managed Care Hassle Factor, ASIM 98, reaffirmed BoR 10)

Board Certification

Internal medicine board certification, by itself, should not be used to exclude or include physicians from participation in health care plans, employment opportunities, or hospital privileges. Objective criteria other than board certification should be considered to obtain a more accurate assessment of an internist's clinical judgment and competence. These criteria should include:

1. Meeting the training requirements necessary to sit for the certification examination of the American Board of Internal Medicine or American Osteopathic Association Board.
2. Completion of an ACGME or AOA approved internal medicine residency.
3. Faculty appointment in a medical school or participation in teaching residents and medical students.
4. Evidence of extensive continuing medical education (CME).
5. Appointments to peer review or quality assurance committees.
6. Evidence of a large, busy practice of satisfied patients.
7. Documentation of good standing in the medical community.
8. Clinical privileges granted by a hospital medical staff.
9. Outcome measures.

ACP continues to vigorously promote these and other criteria of clinical experience in providing quality patient care to medical associations, managed care entities, employer groups, and accrediting organizations. (HoD 95; reaffirmed BoR 08)*

Recertification

1. ACP reaffirms its commitment to lifelong learning and professional accountability through the process of recertification.
2. All pathways for recertification must meet the following criteria: relevance to a variety of practice settings, elimination of redundancy, accommodation to different learning styles and sensitivity to cost and time.

3. Whatever methods of recertification are chosen must be subject to continuous testing and validation.
4. It is the position of the ACP to encourage the maintenance of certification of subspecialists in both general internal medicine and their subspecialties and therefore continue to work with the ABIM to eliminate barriers and facilitate the process of dual recertification in both general internal medicine and the subspecialties. (BoR 02)

Physician Contracting

ACP supports federal preemption of state laws that unfairly interfere with the ability of health plans to establish the contractual conditions of participation by physicians and other providers in the plan, provided that the health plans are required to comply with federal standards to protect the interests of patients in those plans, including the requirements specified below:

1. Health plans that contract with selected physicians to furnish care should utilize selection criteria based on professional competence and quality of care and appropriate economic considerations.
2. Health plans that contract with selected providers should have an established mechanism by which any provider willing to abide by the terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan.
3. Health plans or networks should provide public notice within their geographic service areas when physician applications for participation are being accepted.
4. Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have the application judged on the basis of objective criteria that are available to both applicants and enrollees.
5. Selective contracting decisions made by any health care delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriate utilization and resources. In general, no single criterion should provide the sole basis for selecting, training, or excluding a physician from a health delivery or financing system. The projected staffing needs of the contracting entity to serve its patient population is a valid criterion that may be used for provider selection.
6. Plans should provide for review by a credentialing committee with appropriate representation of the applicant's medical specialty of all applications to participate in the plan. Any economic profiling of physicians should be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher than or lower than expected costs.
7. Plans should be prohibited from excluding practitioners with practices containing a substantial number of patients with expensive medical conditions.
8. All decisions should be on the record and the physician applicant should be provided with all reasons used if the application is denied or the contract not renewed.
9. After an initial probationary period, plans should not be allowed to include clauses in physician contracts that allow for the plan to terminate the contract "without cause."
10. Prior to initiation of actions leading to termination of a physician's participation contract "for cause," the physician should be given notice specifying the grounds for termination. Physician contracts should provide for an appeal process and remedies if applicable. (HoD 93; reaffirmed BoR 04)*

Prohibition on Gag Clauses

ACP believes that no contract between a health care payer and a physician should contain any provision

restricting the physician's ability to communicate information to the physician's patient regarding medical care or treatment options for the patient when the physician deems knowledge of such information by the patient to be in the best medical interest of the patient. (HoD 96; reaffirmed BoR 08)*

Availability of Physician Payment Information

1. All health insurance plans should be required to make detailed information on compensation arrangements readily available to physicians, including fee schedules, relative values and conversion factors of services, capitation arrangements, percent of premium and other physician incentive plans such as withholds and bonuses.
2. General information regarding the type of payment methodology (e.g. salary, fee-for-service, withhold/bonus, percent of premium, or capitation) from insurers to physicians for the delivery of medical services should be made available to patients upon request to the health insurance plan. (HoD 97; reaffirmed BoR 08)*

Assuring Physician Reimbursement, Incentives, and Financial Risk Sharing Do Not Compromise Patient Care

1. All health plans must assume responsibility to assure that financial risk-sharing methods do not lead to compromised patient care, which capitation and other risk-sharing methods may do. The plans need to be open to proposals from physicians to restructure their capitation arrangements to reduce any potential adverse impact on patients. It is not sufficient for health plans to argue that the responsibility for assuring that appropriate care is given falls solely on the physician, when it is the health plan that determines the financial arrangement under which medical care is provided.
2. All health plans should offer stop-loss coverage to all physicians. Physicians should be required to obtain stop-loss coverage if their capitation contains risk provisions beyond the services that the physician provides (for example, sharing risk for hospital care).
3. Risk-bearing capitation payments should be based on a minimum enrolled patient population of 250 or more patients per physician. If an internist has fewer than a group average of 250 patients per plan, the internist should be compensated under a fee-for-service or a primary-care capitation payment mechanism.
4. Managed care plans that use a "gatekeeper" model should require either that patients select a primary care physician within 30 days of enrollment, or the plan will select a primary care physician for the patient. If, for some reason, a primary care physician is not selected within this time frame, health plans that use a capitation payment mechanism must pay the primary care physician who first sees the patient a capitation payment for that patient retroactive to the enrollment date.
5. Health plans should modify the methods they use to determine capitation payments to include several factors, in addition to age and gender, that can predict use of medical care resources. Specifically, ACP recommends that health plans incorporate measures of health status and prior-year utilization.
6. Patients should be informed, at the time of enrollment, of any financial arrangements--including capitation--that place physicians at risk for the services that they provide to patients.
7. Health plans that capitate physicians should provide a fee-for-service, point-of-service option.
8. Health plans should use the most current work relative value units as found in the Medicare fee schedule methodology in determining their reimbursement mechanisms.
9. Most importantly, internists have a responsibility to do everything they can to assure that patient care is not compromised when they accept financial risk for clinical decisions.
10. Managed care contracts should include provisions to protect physicians from adverse selection

when certain high-cost patients with preexisting conditions sign up with the primary care physician, (e.g., patients with active AIDS, organ transplants or end-stage renal disease). Specified high-cost patients with pre-existing conditions should be excluded from the individual capitation rate and handled on a fee-for-service or capitation carve-out basis. (Reinventing Managed Care: Assuring Appropriate Patient Care Under Capitation Arrangements, ASIM 95; reaffirmed BoR 08)

11. ACP supports changes in regulation and/or legislation so that managed care plans' financial incentives to physicians include valid outcomes measures in determining the provision of these incentives. (HoD 96; reaffirmed BoR 08)
12. ACP supports legislation requiring that physicians in capitated arrangements receive notification of insurance status of the names of eligible enrollees and non-eligible disenrollees within thirty days of such changes. Payment for eligible enrollees from all payers should be made within 30 days of enrollment, with appropriate penalties for lack of compliance in payments for all capitated patients. (HoD 96; reaffirmed BoR 08)

Physician and Health Plan Liability

1. Managed care organizations should be held responsible for assuring quality health care and be held liable for any negligence on the part of the health plan resulting in patient injury.
2. ACP will work to modify ERISA laws which prevent personal injury and wrongful death actions being brought against health plans in state courts. Deserving claimants should be allowed to bring personal injury and wrongful death cases in state courts against health plans and managed care organizations if the utilization review or preauthorization protocols influenced the provider's care and the care was a contributory cause of the injury or death. (HoD 97; reaffirmed BoR 08)*
3. ACP opposes physician and physician-in-training liability in cases where they have been restricted in their treatment and referral decisions by managed care plans. (HoD 96; reaffirmed BoR 08)*

Health Plan Marketing Standards

1. ACP encourages the U.S. Congress and through the ACP component societies the legislative bodies of the respective states to enact appropriate legislation designed to prevent the use of fraudulent, deceptive and high-pressure sales tactics to enroll patients in health insurance plans, and to penalize those individuals and organizations which promote such activity. (HoD 96; reaffirmed BoR 08)*
2. State and Federal standards for marketing health benefits plans must ensure that: marketing materials must not include false or materially misleading information; and sales agents do not partake in abusive enrollment procedures such as not showing potential beneficiaries the listing of covered insurance benefits. (HoD 94; reaffirmed BoR 04)*

For-Profit Conversion of Health Care Organizations

In order to protect the general public in regard to for-profit conversion of health care organizations, ACP recommends the following:

1. Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health organizations.
2. Public notice and subsequent public hearings should be required prior to the approval of a for-profit conversion.
3. The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance

commissioner) overseeing the for-profit conversion.

4. For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals.
5. If the establishment of a charitable foundation is required as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion.
6. The mission of a charitable foundation resulting from a for-profit conversion should reflect closely the original mission of the non-profit health care organization.
7. A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation.
8. The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations. Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions.
9. Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports).
10. There should be meaningful physician presence on the board of directors of any charitable foundation formed as a result of the conversion of a non-profit health care organization to a for-profit organization. (BoR 98, reaffirmed BoR 10)

Accountability of Medical Director

In order to ensure fairness to physicians providing care and patients receiving care through managed care plans, and to ensure that managed care medical directors are held accountable for their actions, ACP believes that the final determination of a managed care plan's denial of services or benefits based on lack of medical necessity or appropriateness must be made or reviewed by the plan's medical director, who must be fully licensed to practice medicine in the state in which the claim arose. Clear instances of poor clinical judgment on the part of the medical director, causing potential harm to a patient, should be reported to the state licensing board. (HoD 95; reaffirmed BoR 08)*

Utilization Review (UR) and Utilization Management (UM)

1. UR/UM policies must never place physician financial incentives in conflict with patient welfare.
2. Physicians' adherence to evidence-based, scientifically supported practice guidelines should result in payment without excessive demands for documentation and without filing appeals. If the patient care does not comply with these guidelines, the physician should provide information to justify the claim.
3. UR/UM appeals should provide physicians with due process, including the right to review the material used to make the claims denial with the actual personnel responsible for the review.
4. Managed care plans should reveal UR/UM criteria--such as computer algorithms, screening criteria, and weighting elements--to physicians and their patients, on request.
5. Managed care plans should require preauthorization only for services for a specified procedure if there is clear evidence that: (1) Routine use of preauthorization substantially reduces the number of medically unnecessary services; and (2) The costs of conducting the preauthorization--

including costs incurred by the physician's office in complying with the preauthorization requirements--do not exceed the potential savings.

6. Managed care plans should require that UR/UM personnel and processes focus on medical procedures that have a consistent pattern of overutilization, pose significant medical or financial risk to the patient, or for which there are no clear medical indications for use.
7. Managed care plans should apply uniformly the UR/UM criteria established or endorsed by a UR/UM organization or the medical community, based on sound scientific principles and the most recent medical evidence
8. Managed care plans should ensure that the UR/UM process is educational. Instead of punishing physicians or preventing appropriate care, the process should alert physicians to practices that may not be cost-effective and efficient. UR/UM should encourage physicians to examine methods for altering practices and procedures while viewing high quality patient care as their priority.
9. Managed care plans should not exclude physicians who have served as patient advocates in appealing UR/UM decisions.
10. Managed care plans should not initiate UR/UM contracts intended to deny medically necessary services.
11. Managed care plans should not base the compensation of individuals who conduct UR/UM on the number or monetary value of care denials.
12. Managed care plans should accept a prudent layperson's assessment of an emergency condition in determining when to pay for initial screening and stabilization in the emergency room. Managed care plans should base the determination on what the patient knows at the time of seeking the emergency care, rather than on what the emergency department visit reveals.
13. With input from practicing physicians, the managed care plan industry should standardize utilization review authorization processes. (Reinventing Managed Care: Reducing the Managed Care Hassle Factor, ASIM 98)
14. All insurers requiring pre-approval for the provision of medical services (Diagnostic and/or therapeutic) must provide an approval mechanism 24 hours a day; and a physician must be available on-call 24 hours a day to review and adjudicate any denials. All insurers rejecting the provision of medical services (diagnostic and/or therapeutic) must provide the specific reason for said action at the time of rejection). (HoD 95; reaffirmed BoR 08)*

ACP supports the following principles regarding utilization review entities involved in Concurrent Review of Inpatient Care provided by Managed care plans:

1. Third-party reviewers who are on site in hospitals evaluating inpatient management must submit their credentials for identification and must obtain clinical data in the hospital only under the supervision of hospital-based utilization review/quality assurance programs.
2. Medical protocols and other relevant medical review processes used in a health plan's concurrent review program should be established with appropriate involvement from physicians.
3. Professionally accepted pre-established review criteria, that is evaluated and updated periodically, should be used for concurrent review.
4. The UR entity should inform, upon request, designated hospital personnel and/or the attending physician of the UR requirements. However, the UR firm should collect only that information which is necessary to certify the admission, procedure or treatment and length of stay. Copies of medical records should only be required when problems occur in certifying the medical necessity

of admission or extension of stay and only pertinent sections of the medical record should be required.

5. UR organizations should make available to hospitals, physicians and other health care professionals the general contact procedures to be followed in verifying the identity of the review personnel requesting information, in calling for review and appeals information, and in registering concerns about any element of the review process. UR staff should be available through a toll free telephone number to answer such inquiries during normal business hours of the provider's time zone.
6. After hours contact procedures should be specified, as well as a means for expedited review.
7. Initial concurrent review should be conducted by trained individuals using medical and/or benefit screening criteria established or endorsed by the UR entity in consultation with the medical community.
8. Concurrent review should be done on a targeted basis.
9. When necessary, concurrent review conducted by telephone should be supplemented by reviewer and provider examination of the patient's medical record.
10. Concurrent review should be initiated after a reasonable period of time following admission and conducted at reasonable intervals thereafter. Routine daily review of all patients should not be conducted by the UR firm. Frequency of review should be based on the patient's medical condition.
11. The attending physician and/or hospital should be informed of the length of stay certified and the next anticipated review time. Generally, routine concurrent review should not be conducted earlier than 24 hours prior to the end of the certified length of stay.
12. All review organizations must have a medical advisor, preferably licensed in the state in which the review is conducted. Decisions by the reviewer to certify additional services or continued stay should be conveyed to the attending physician by telephone or in writing within one working day of receipt of information needed to complete the review. Decisions not to certify continued stay for reasons of medical necessity should be reviewed by a physician advisor of the reviewing entity. This advisor should be available by telephone for consultation with the attending physician.
13. The attending physician should be notified as soon as possible of a denial of continued stay and given the opportunity to appeal the decision on an expedited basis. Reconsideration of the denial may also be handled through the standard appeals process.
14. A decision by the reviewing entity to uphold the denial or continued stay should be conveyed to the attending physician and/or hospital by telephone the same working day. A written confirmation of the denial should follow and include an explanation of the primary reasons for the denial and procedures to initiate further appeal, if the patient so chooses.
15. If the initial appeal is still denied after reconsideration, the attending physician should have the right to ask for additional review by another physician advisor or medical consultant of the appropriate medical specialty.
16. On-site third party reviewers should communicate all suggestions regarding patient management directly to the attending physician and should document all such actions in accord with medical staff policy. (HoD 92; reaffirmed BoR 04)*

Physician Run Health Plans, Professional Accountability, and Anti-Trust Considerations

1. ACP encourages physician-led integration as the surest way to retain professional values at the

core of the health care system. A physician organization should be bound first and foremost to professional values, while commercial organizations are bound to stockholders. Additionally, both evidence and logic suggests that integrated practice and professional collaboration may improve quality of life.

2. In all forms of integration, physicians should have a commitment to and a central role in accountability processes. This necessitates the involvement of physicians at the highest levels of organizational leadership, particularly in the areas of quality and utilization management, and the collaborative involvement of all physicians in these processes. Legislation and licensing of health care delivery organizations should require physician leadership of utilization and quality management in all organizations.
3. Highly integrated practices with established quality and utilization systems are better positioned to deliver quality, cost-effective care than are loosely-knit networks or individual practices, which do not have the necessary tools.
4. In choosing any type of practice organization, physicians have the responsibility to evaluate and place a high priority on physician development and leadership of collaborative quality improvement and clinical activities and on overall physician leadership in the organization. ACP supports the right of physicians to choose any type of practice arrangement.
5. Patients have the right to full disclosure of all methods of reimbursement, quality management, and utilization review in any health care delivery organization. Legislation and licensing should require such disclosure.
6. No delivery organization, accountability process, or reimbursement structure can fully resolve the conflicts posed between economic self-interest and professional commitment to the patient's best interest. Neither purchaser demand nor regulatory oversight can stimulate the type of quality that comes from professional commitment to altruism, research, and self-improvement.
7. Professional societies have a responsibility to support physicians attempting to form integrated organizations by providing information, guidance, and referrals; by arranging support networks; and by sponsoring or financing educational programs.
8. Medical schools should include instruction on health care economics, business issues, cost-efficient practice patterns, epidemiology, population-based medicine, and evidence-based practice. Alternatively, medical schools, like the profession itself, are called on to impart a milieu that supports collaborative practice.
9. ACP, other professional organizations, universities, and government should support vigorous research of the effects of various types of integration and reimbursement structures on clinical outcomes, population-based health status measures, patient satisfaction data, and functional health status measures. (Physician-Driven Integration: A Response to the Corporatization of Medicine, ACP 96; reaffirmed BoR 08)

Establishing Strategy that Uses Anti-Trust Laws to Prevent Insurance Market Domination by One or Few Carriers

The American College of Physicians advocates that anti-trust laws be changed to prevent market domination by one or very few insurers which harm patients' freedom to choose insurers, unfairly increase costs of health care for consumers and employers, and prevent physicians from negotiating over provision of health services with those insurers. (BoR 04)

Establishing Strategy to Allow Physicians to Collectively Negotiate with Insurers

The American College of Physicians supports federal and state legislation which expressly grants physicians the ability to jointly negotiate with insurers. (BoR 04)

Supporting the Use of Physician Office Labs (POLs) in a Managed Care Setting

1. Managed care plans should reach agreement with their participating physicians on the types of laboratory tests that should be routinely made available in the physician's office--based on the specialty of the Physician running the lab--so the appropriate tests that contribute to prompt diagnoses are available to the patient.
2. Managed care plans should not require patients to travel to a reference lab to get their tests done. Physicians should be reimbursed an adequate fee for the in-office drawing and handling of tests that are sent to a reference lab for testing.
3. Managed care plans should survey enrollees on their satisfaction with access to laboratory services and make changes in their laboratory arrangements--such as expanding access to POLs--if such surveys support a conclusion that patients prefer to have their tests done in their doctor's office.
4. Managed care plans should be willing to negotiate with individual doctors and medical group practices to expand the menu of laboratory tests that may be provided in the physicians individual POL beyond the minimum testing set necessary.
5. Managed care plans should compare the costs of tests sent to outside reference labs to POLs and allow POLs to provide laboratory tests at a competitive rate.
6. Managed care plans should address concerns about potential over-utilization of laboratory tests in POLs by using severity-adjusted and specialty-specific profiling, or by negotiating arrangements that include placing physicians at financial risk for lab tests, rather than prohibiting physicians from providing in-office tests.
7. To address quality concerns, Managed care plans should consider requiring all labs--POLs and reference labs--to participate in proficiency testing and to obtain accreditation from COLA or other accrediting organizations. (Reinventing Managed Care: Assuring Appropriate Access to Laboratory Testing for Patients in Managed Health Care Plan, ASIM 96; reaffirmed BoR 08)

Statement on Arbitrary Classifications that Restrict the Practice of Internal Medicine

The College opposes arbitrary categorizations that restrict internists from providing health care services for which they are trained and qualified to deliver. Patient access should not be limited based solely on the specialty designation of the physician. Physicians should be permitted to practice in areas for which they are appropriately trained and can demonstrate that they are currently knowledgeable and clinically competent.

The ACP maintains that physicians should be permitted to practice in areas for which they are appropriately trained and can demonstrate that they are currently knowledgeable and clinically competent. Accordingly, requirements by insurers and other third-party payers that physicians must choose between being a primary care physician and a specialist are inappropriate. (Statement on Arbitrary Classifications that Restrict the Practice of Internal Medicine, ACP 96; reaffirmed BoR 11)

Use of Board Certification

Board certification, by itself, should not be used to exclude or include physicians from participation in health care plans, employment opportunities, or hospital privileges. (HoD 94; reaffirmed BoR 04)*

Managed Behavioral Health Organizations (MBHOs)

1. Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care physicians.
2. When a patient's mental health care is managed and/or administered by an MBHO, with the patient's permission, the primary care physician should be immediately notified and kept apprised of the patient's treatment and progress, so that the primary care physician can coordinate the

patient's health care needs in optimal fashion. (BoR 00; reaffirmed BoR 11)

MANAGED CARE: MEDICAID

Monitoring

ACP supports uniform criteria for monitoring the transformation of Medicaid into state programs providing coverage through managed care plans and the impact of such changes on access and quality. Suggested criteria for monitoring and review include (1) adequacy of public notification of pending charges, (2) phased implementation allowing sufficient time for a managed care infrastructure to develop and for a smooth transition for both patients and providers, (3) sound financial underpinnings with capitated payments actuarially based on analysis of expected utilization and enrollment of the covered population, and (4) uniform standards of quality.

Medicaid Waivers for Managed Care Demonstration Projects

Criteria for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act should be that the proposed project (1) assist in promoting the Medicaid Act's objective of improving access to quality medical care, and (2) has been preceded by a fair and open process for receiving public comment on the program. (ACP AMA Del I-94; reaffirmed BoR 04) ACP supports the 1115 waiver process, but urges that renewal requirements for waivers be flexible enough to provide for long-range planning with predictable and sufficient funding. (BoR 00; reaffirmed BoR 11)

State Medicaid Managed Care Programs

ACP supports:

1. State governments should demonstrate to the federal government the organizational capacity and structure sufficient to operate a Medicaid managed care program.
2. States should conduct appropriate education and outreach programs to their Medicaid populations to familiarize them with the rules of managed care. To avoid confusion on the part of recipients and providers created by automatic enrollment policies, states should be required to notify enrollees concerning any health plans to which they may be assigned and the need to use a health plan's network of providers.
3. States should establish a statewide grievance system for their Medicaid managed care program for use by enrollees and providers to report instances of fraud and abuse or unreasonable denials of care.
4. States should have the authority to impose fines, terminate enrollment and cut off payments to health care plans violating the standards of the Medicaid managed care program.
5. States should be encouraged to adopt independent enrollment brokers for their Medicaid managed care plans to remove incentives for marketing abuses.
6. State contracts with Medicaid managed care plans should include standards for accountability and management of the health plan and should include review of a health plan's medical necessity standards and preauthorization rules to ensure that the health plan's standards of care are consistent with those in the medical community.
7. Similar regulatory standards should be applied to Medicaid plans as those applied to commercial managed care plans, including accreditation by an established third party accrediting body and licensing by a state insurance department or equivalent licensing body.
8. Rules on marketing by Medicaid managed care plans should be strengthened, including prohibitions on door-to-door canvassing in low-income areas, marketing at food stamp offices and offering gifts as incentives to join a plan.
9. Background checks should be conducted by the state on health plan owners and managers, with

prohibitions against granting of an HMO license to anyone with a criminal background or deemed lacking in managed care expertise.

10. Health plans should be required to report to the appropriate state agency the salaries of plan executives and to spend at least 80 percent of their Medicaid payments on health care services and medical care.
11. Health plans should be prohibited from considering an individual's health status during the enrollment or reenrollment process or for purposes related to underwriting.
12. To alleviate problems associated with rotating enrollment, beneficiaries who join a managed care plan should be required to remain in the plan for the remainder of the plan year, after an initial 60 day trial period. (HoD 96; reaffirmed BoR 08)*

MANAGED CARE: MEDICARE

Physician Contacts with Medicare-HMO Intermediaries

The American College of Physicians endorses the principle that it is inappropriate for Medicare Advantage intermediary contracts with physicians to contain any clause that would proscribe the capacity of the physician to bill another government or commercial insurance carrier such as State or Federal worker's compensation, automobile, medical, no-fault, or liability insurance – including a self insured plan. (BoR 98, reaffirmed BoR 10)

Disclosure of Information to Beneficiaries/Enrollees

ACP believes that the information described below should be disclosed to enrollees and potential enrollees prior to enrollment, at least once annually thereafter, and at any time that the managed care plan substantially modifies its established rules or policies. Managed care plans should be required to provide this information to beneficiaries written and formatted in the most easily understandable manner possible:

1. Require Managed care plans to provide beneficiaries with information written and formatted in the most easily understandable manner possible that explains:
 - a. Written rules and policies regarding benefits;
 - b. How and where to obtain services from or through the managed care plan;
 - c. Restrictions on coverage for services furnished outside the managed care plan, including the extent to which enrollees may select the providers of their choice (from within or outside the plan's network of providers if applicable), and the restrictions (if any) on payment for services furnished to the enrollees by providers other than those participating in the plan;
 - d. The obligation of the managed care plan to assume financial responsibility and to provide reasonable reimbursement for emergency services and urgently needed services;
 - e. Any services other than emergency or urgently needed services that the managed care plan chooses to provide;
 - f. Premium information;
 - g. Grievance and appeal procedures including the right to address grievances to the Secretary of Health and Human Services (HHS) or the applicable review entity;
 - h. Disenrollment rights;
 - i. Any restrictions that limit coverage to prescription drugs approved by the managed care plan (i.e., drug formularies);
 - j. Any prior authorization requirements for inpatient admissions, elective procedures or referrals;

- k. Any rules that require beneficiaries to obtain authorization from a primary care physician (PCP) to cover referrals for tests, elective procedures and specialty care; and
 - l. Any rules that limit access to clinical laboratory tests performed in participating physicians' offices.
2. Require Managed care plans to inform beneficiaries of their right to be informed about various treatment options including:
 - a. The right to discuss with their physician the advisability of seeking treatment options that may not be available through the managed care plan or for which the managed care plan will not authorize coverage; and
 - b. The right to decline treatment.
 3. Require managed care plans to disclose their:
 1. Disenrollment rates for Medicare enrollees for the previous two years (excluding disenrollment due to death or moving outside of the plan's Medicare service area);
 2. The number and percentage of claims for payment of services for the previous two years that were denied by the plan and appealed to the Secretary of HHS, an administrative law judge, or federal court under the appeals procedures that are available to beneficiaries; and disclose the number and percentage of such denials that were reversed upon appeal.
 3. The number and percentage of participating providers for the prior three years whose contracts with the managed care plan were not renewed by action of the managed care plan or the provider.
 4. Their medical expense ratio, using a standard reporting format as required by the Secretary. A medical expense ratio represents the proportion of total revenue spent on medical services, as opposed to the proportion spent on administrative expenses, retained or distributed to owners.

Any restrictions placed on the information that participating providers are allowed to discuss with or otherwise communicate to beneficiaries.

1. Using a standard reporting format as required by the Secretary of HHS, require that the managed care plan provide a report card on the satisfaction of enrolled beneficiaries and participating physicians with the plan. As a basis for preparing such report cards, require managed care plans to use a standard survey instrument (as specified by the Secretary) to survey beneficiaries and their participating physicians at least once annually on their satisfaction with the managed care plan-- including assessments by enrolled beneficiaries and by participating providers of the quality of care provided, and the ease by which beneficiaries can access needed services and obtain care from physicians who are most qualified to treat them.
2. Require managed care plans that have physician incentive plans (as defined by current regulations), provide a written disclosure--based on standard definitions and explanations as established by the Secretary of HHS--of the impact that such arrangements can have on patient care, including the financial incentives that are created for providers to provide fewer services to beneficiaries. The recently released physician incentive plan regulations need to be improved by standardizing the information that must be provided to patients, rather than leaving it to the plans to decide on the wording and content of the disclosure statements. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Congress should direct the Secretary of HHS to develop a comparative information packet on the

competing managed care plans. CMS would provide the packet--upon request--to any Medicare beneficiary who is considering enrolling in a managed care plan. The types of information should include:

1. Enrollment and disenrollment rates;
2. Comparative performance on clinical, structural, and satisfaction benchmarks;
3. Access measures, including the percentage of referrals denied or unavailable;
4. Physician turnover rates;
5. Satisfaction measures (specifying those with chronic conditions) including disenrollment information;
6. Appeals and grievance procedures, including the numbers, reasons, and resolutions of grievances and appeals per managed care plan;
7. Access and quality findings from CMS monitoring surveys;
8. Information on how referrals are made, including who makes the referrals and on what basis;
9. Financial and contractual arrangements between plans and providers that may influence their decisions regarding services, in the judgment of the federal government. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96, reaffirmed BoR 08)

Choice of Physicians in Medicare Managed Care Plans

In order to assure beneficiaries' freedom to choose the physician who is best qualified to treat them, Medicare Managed care plans should meet the following standards concerning enrollee choice of physician:

- a. Enrollees should be able to select a personal physician from among all participating plan physicians.
- b. If a plan limits benefits to items and services furnished only by providers in a network of providers which have entered into a contract with the sponsor, the sponsor must also offer at the time of enrollment a Point-of-Service (POS) rider to cover items and services furnished by health professionals who are not participating providers. A supplemental premium could be charged for such a rider and cost-sharing rules imposed by the managed care plan for out-of-plan services.
- c. For the POS option, the HHS Secretary should establish an actuarially sound schedule of limits on cost sharing for out-of-plan items and services. These cost-sharing limits must be applied uniformly to all POS offerings. Cost-sharing for such items and services for lower-income enrollees should be appropriately lower than limits established by the Secretary for other enrollees and should be set at a level that would not pose an unacceptably large financial burden to obtaining out-of-network services. For purposes of cost-sharing, lower income enrollees are defined as individuals who have adjusted gross income below 250% of poverty level. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Provision of Care to Enrollees with Chronic Conditions and Special Needs

In order to assure beneficiaries--especially those with chronic conditions and special needs--have timely and convenient access to the full range of needed physician services, Medicare Managed care plans should be required to:

1. Develop and implement standards for accessibility to hospital-based services and to primary and specialty care physician services. These accessibility standards shall ensure the plan establishes and maintains adequate arrangements with a sufficient number, mix and distribution of health professionals and providers to assure that items and services are available to each enrollee in the

service area of the plan; in a variety of sites of service; with reasonable promptness (including reasonable hours of operation and after-hours services); with reasonable proximity to the residence and workplace of enrollees; and in a manner that takes into account the diverse needs of enrollees and that reasonably assures continuity of care.

2. Develop and implement standards to allow for the addition of providers to meet patient needs based on increases in the number of enrollees, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.
3. Develop and implement standards to ensure that processes for coordination of care and control of costs do not create undue burdens for enrollees with special health care needs or chronic conditions. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Enrollees' Access to Urgent and Emergency Care Services

In order to assure beneficiaries have immediate access to urgent and emergency care, Medicare Managed care plans should:

1. Use a prudent layperson's assessment of what constitutes an emergency condition as one of the factors in determining when it should pay for initial screening and stabilization in the emergency room. The determination should be based on what is known by the patient at the time the emergency care is sought, rather than what is later learned as a result of the emergency department visit. Additional evaluation and treatment services should be provided consequent to a medical professional's screening, so a different standard would apply to coverage of such services.
2. Make timely decisions on requests for preauthorization of emergency and urgent care services. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Enrollees' Grievance and Appeals Rights and Procedures

Medicare Managed care plans should be required to meet the following appeals and grievance criteria:

1. As required under existing standards, the managed care plan should ensure that all enrollees receive written information about the appeals and grievance procedures at the time of enrollment. Given the findings by GAO and OIG that some Managed care plans have been violating this requirement without being sanctioned by CMS, CMS should strictly enforce this requirement and impose sanctions on plans that are not in compliance.
2. The managed care plan should review an adverse preauthorization determination upon request of the enrollee, enrollee's family or enrollee's physician--within specified time frames that would allow for a rapid determination of denials for urgent and emergency care. CMS's current standards do not include any specific requirements for timely review of emergency and urgent care. ACP proposes the following time frames:
 - a. For urgent care services, within one hour after the time of the request for such review;
 - b. For services other than emergency and urgent care, within 24 hours after the time of a request for such review.
3. The managed care plan should review an initial determination on payment of claims within 45 days after the date of a request for such review by the enrollee, enrollee's family or recipient of payment (provider), instead of the 60 days allowed under the existing standards.
4. The managed care plan should review a grievance regarding inadequate access to any physician specialist by an enrollee, the enrollee's family, or the enrollee's physician, within five business days. The current standards do not include any specific requirements on timely reviews of

complaints concerning inadequate access.

5. The managed care plan should inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee and enrollee's physician of his/her right to reconsideration.
6. The managed care plan preauthorization/claims payment reviewer described in this section should be of the same or similar medical specialty as the provider of the service in question.
7. A request for a second reconsideration should be made in writing by the enrollee, enrollee's family or enrollee's physician and filed with the managed care plan or the Social Security Administration office within 60 days of the organization determination. The enrollee should request an extension if "good cause" is shown. The managed care plan should make a second reconsideration within 30 days, instead of the 60 days now allowed, and for access complaints, within five days. If the managed care plan does not reconsider in the beneficiary's favor, it should prepare a written explanation for all parties involved with the dispute and send the entire case to CMS for a determination.
8. The managed care plan should be granted an extension from the above time requirements only if the appropriate providers have not forwarded them patient records for review.
9. If the managed care plan does not act within the prescribed time period, the case should be automatically decided in favor of the enrollee. Currently, beneficiaries are still subjected to the managed care plan's original denial of their request for payment of medical services, even when the managed care plan has failed to comply within the time frames for review in the existing standards. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Handling of Reconsidered Appeals Determinations

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

1. As required under current regulations, notify the enrollee, the enrollee's family, the enrollee's physician and the managed care plan of:
 - a. The reasons for the reconsidered determination;
 - b. The enrollee and enrollee's physician's right to a hearing if the amount in controversy is \$100 or more;
 - c. The procedure that the enrollee or enrollee's physician must follow to obtain a hearing.
2. Make a reconsidered determination within 30 days for denials of covered services, as currently required, and within five days for access complaints.
3. As required under existing standards, inform the parties involved with the complaint of its decision in writing. The notice should state the specific reasons for the determination and inform the enrollee of his/her right to a hearing for reconsideration.
4. Establish that the reconsidered determination is final and binding unless a request for a hearing is filed within 60 days of the date of the notice of reconsidered determination by the enrollee, the enrollee's family or the enrollee's physician.
5. Decide the case in favor of the enrollee if CMS or its contractor does not act within the prescribed time period (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Quality Improvement Organizations (QIOs) Review of Disputed Inpatient Lengths of Stay

Medicare should maintain its current standard requiring QIOs to immediately review disputes between the

managed care plan and the patient over the length of inpatient stays (stated below):

1. A Medicare enrollee, enrollee's family or enrollee's physician who disagrees with a determination made by the managed care plan that inpatient care is no longer necessary may request immediate QIO review of the determination.
2. The enrollee may stay in the hospital until the QIO makes a determination.
3. The PRO must make a determination and notify the enrollee, the enrollee's physician, the hospital and the managed care plan by the close of business the first working day after it receives the information from the parties involved necessary to make a determination. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Standards for CMS Appeals Contractors

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

1. The contractor should be required to establish state or regional advisory committees of practicing physicians that reflect various medical specialties, practice settings and geographic areas. The advisory committees should:
 - a. Review the contractor's performance on reviewing and adjudicating claims disputes;
 - b. Review newly proposed Medicare policies and policy changes as required by CMS;
 - c. Address generic managed care problems raised by CMS, the contractor, QIOs, carriers, Managed care plans, physicians or beneficiaries. However, the committee will not involve itself with individual physician disputes with an managed care plan or the contractor;
 - d. Meet with the contractor on a quarterly basis;
 - e. Make quarterly, formal reports to local and state medical associations and specialty societies.
2. The contractor should provide for timely notification and adequate opportunity for review by state medical societies and specialty societies of changes in criteria, protocols or other standards used by the contractor in making determinations about disputed claims.
3. The contractor should disclose to physicians and beneficiaries, upon request, all coding edits, medical necessity criteria, algorithms and practice guidelines used to review denials by Managed care plans. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Utilization Review (UR) Requirements for Medicare managed care plans

1. Medicare Managed care plans should establish utilization review (UR) programs with the involvement of participating physicians and release to affected health providers and enrollees the screening criteria, weighting elements and computer algorithms used in reviews and a description of the method by which these were developed.
2. Medicare Managed care plans should uniformly apply UR criteria that are based on sound scientific principles and the most recent medical evidence
3. Medicare Managed care plans should use licensed, certified or otherwise credentialed health professionals in making review determinations and, subject to safeguards outlined by the Secretary of HHS, make available upon request the names and credentials of those conducting UR.

4. Medicare Managed care plans should be explicitly prohibited from compensating individuals conducting UR based on numbers of denials.
5. Medicare Managed care plans should treat favorable preauthorization reviews as final for payment purposes unless the determination was based on fraudulent information supplied by the person requesting the determination.
6. Medicare Managed care plans should provide timely access to review personnel and, if such personnel are unavailable, waive any preauthorization that would otherwise be required. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assuring Quality of Care--Managed Care Plan Responsibilities

In order to assure that internal and external reviews of the Quality of Care Provided by managed care plans are sufficient for beneficiaries to obtain necessary and beneficial care, Medicare managed care plans should be required to:

1. Establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians and providers that improve quality of care into:
 - a. Medical policies of the plan (such as policies relating to coverage of new technologies, treatments and procedures;
 - b. Quality and credentialing criteria of the plan;
 - c. Medical management procedures of the plan.
2. Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.
3. Evaluate the continuity and coordination of care that enrollees receive.
4. Have mechanisms to detect both underutilization and overutilization of services.
5. Use systematic data collection of performance and patient results, provide interpretation of these data to its practitioners, and make needed changes.
6. Make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate). (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assuring Quality of Care--CMS Responsibilities

In order to assure that internal and external reviews of the quality of care provided by Managed care plans are sufficient for beneficiaries to obtain necessary and beneficial care, CMS should:

- a. Require managed care plans to regularly report patterns of utilization of services, availability of such services and other information to track utilization, access and satisfaction of enrollees.
- b. Routinely publish comparative data collected on HMOs such as complaint rates, disenrollment rates, rates of outcomes and appeals as well as the results of its investigations or any findings of noncompliance by HMOs.
- c. Check the effectiveness of a plan's quality assurance and utilization management processes and, using trained clinical evaluators, include in that examination a systematic consideration of any QIO findings concerning the quality of the plan.
- d. Impose an appropriate level of sanctions when a significant quality deficiency is detected--until such deficiencies are rectified--such as freezing enrollment in the plan by stopping payment for new

Medicare enrollees.

- e. Provide for private sector accreditation as an alternative to federal review and certification of Managed care plans, provided that a deemed accrediting body's standards are equal to or stronger than the standards outlined for managed care plans by CMS.
- f. Provide for external monitoring--by an independent, publicly accountable group--of the effectiveness of the managed care plan's internal quality improvement processes, emphasizing collaborative efforts to improve quality rather than micromanagement. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

CMS Application of Statutory Sanctions for Sub-Standard Quality of Care

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

1. Failure to provide medically necessary services required by a beneficiary;
2. Requiring enrollees to pay excess premiums;
3. Inappropriately expelling or excluding a beneficiary from participation;
4. Denying or discouraging enrollment;
5. Falsifying information;
6. Not promptly paying claims;
7. Inappropriately terminating participating physicians. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Use of Quality Indicators Specific to a Medicare Population

1. A new set of quality indicators--developed specifically for the Medicare population--should be used to determine whether a plan is providing appropriate continuity and coordination of care.
2. An managed care plan's internal quality review criteria should ensure that the plan's quality assurance system makes appropriate use of best practices and outcomes information--both processes of care and health status measures--for older persons.
3. Medicare Managed care plans should be required to provide CMS with the clinically relevant data from which valid quality indicators can be produced.
4. Funding should be provided for research on outcomes and to develop quality measures. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Assuring Managed Care Plans are Responsive to the Needs of the Medicare Population

1. Managed care plans not currently serving older persons should be required to modify their existing policies and structure before enrolling Medicare beneficiaries.
2. Medicare Managed care plans should be required to provide ongoing training in geriatrics to their physicians and staff. In particular, plans should train their physicians in concepts of coordinated care using a multidisciplinary team with a focus on geriatric syndromes and diseases with a high prevalence in the elderly. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Measuring Patient and Physician Satisfaction

Managed care plans should be required to regularly perform surveys to determine patient and physician

satisfaction. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Ongoing Medicare managed care plan Internal Monitoring System

Case-by-case review should be eliminated and replaced with a system of ongoing monitoring of practice patterns, quality improvement, and outcomes. (Medicare Managed Care: How to Ensure Quality, ACP 95; reaffirmed BoR 08)

Physician Reimbursement, Financial Incentives, Risk-Sharing, and Avoidance of Adverse Selection

1. CMS should require M\managed care plans that pay physicians on an individual or group capitation basis must adjust their provider capitation payments to reflect the risk selection of the patients assigned to an individual participating provider, using risk adjustment methodologies as approved by the Secretary of HHS for this purpose.
2. To assure that Medicare payments to managed care plans do not create incentives for Managed care plans to discriminate against sicker patients with more complex--and costly--illnesses, the Secretary of HHS should be required to develop a methodology for adjusting Medicare and Medicaid capitation payments to managed care plans to reflect risk selection, paying less to plans attracting favorable selection and more to plans with adverse selection. In developing the methodology, the Secretary shall consider factors such as prior utilization and current health status of beneficiaries. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

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

1. Reviewing the definition of "risk threshold." A 25 percent risk threshold may be too high for physicians in solo or small group practice. CMS should consider developing a graduated risk threshold based upon the size of the physician group or based upon the number of patients in the physician's or physician group's patient panel. Using a graduated risk threshold that is lower on smaller patient panels--for example, 10 percent on a solo physician or patient panels of less than 100 patients--will provide greater protection for enrollees than a 25 percent risk threshold. For larger physician groups and larger patient panels, a 25 per-cent risk threshold is more appropriate.
2. Broadening the regulatory requirement for stop-loss coverage. The initial \$10,000 stop-loss limit for patient panels less than 1,000 patients is too high to protect a solo practice or small group of physicians and their patients from unusually high medical expenses. Similarly, the higher stop-loss limits for patient panel sizes greater than 1,000 patients are too high to adequately protect physicians and their patients from random risk of unusually high medical expenses.
3. Increasing the 90 percent protection above the stop-loss limit to 100 percent; 90 percent stop-loss protection is not an adequate safeguard for patients. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Medicare Risk Contracting

ACP supports the following statements favoring improvements in the current Medicare risk contracting program:

1. revising the method of designating payment in Medicare risk contracts.
2. use of risk adjustments such as history of serious illnesses in setting payments to risk contracting plans.
3. offering beneficiaries a choice of point-of-service HMOs and POPS in addition to staff model

HMOs.

4. requiring that beneficiaries be provided comparative information about all health plan choices available to them.
5. requiring that beneficiaries stay with a health plan until the next annual enrollment period (after an initial 60 day trial enrollment), thereby discontinuing the current policy that allows them to enroll or disenroll on a monthly basis.
6. requiring reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain in the traditional Medicare fee-for-service system.

requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them. (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Assessing Physician Performance in a Medicare Managed Care Plan Setting

In order to assure that the methods used by Managed care plans to assess physician performance are designed and implemented in a manner that will not compromise access and quality, Medicare Managed care plans should:

1. Involve affiliated doctors in network management, and set up--with participating provider input--provider performance evaluation measures.
2. Establish procedures for selection of health professionals based on objective standards of quality that would take into consideration suggestions by professional associations, health professionals and providers.
3. Provide for review of applicants by committees with appropriate provider representation, and written notification to provider applicants of any information indicating that the applying provider fails to meet the standards of the plan, along with an opportunity for the applicant to submit additional or corrected information.
4. Use objective criteria when taking into account economic considerations in the selection process, and make such criteria available to those professionals applying to participate.
5. Adjust economic profiling by taking into account a physician's or health professional's patient characteristics (such as severity of illness) that may lead to unusual utilization of services, and make the results of such profiling available to plan providers involved.
6. Provide potential participating providers with the plan's contracting standards and criteria.
7. Involve participating physicians in developing written policies for disciplinary action and sanctions.
8. Unless the physician poses an imminent harm to enrollees, provide:
 - a. A 90-day notice of a determination to terminate a physician contract "for cause";
 - b. An opportunity to review and discuss all the information on which the determination is based;
 - c. An opportunity to submit supplemental and corrected information;
 - d. An opportunity to enter into a corrective action plan.
9. Not include in its contracts with participating physicians a provision permitting the managed care plan to terminate a contract "without cause." (Reinventing Medicare Managed Care: Improving Choice, Access, and Quality, ASIM 96; reaffirmed BoR 08)

Medicare Managed Care Plan Reimbursement for Medical Education, Training, and Research

Medicare payments to capitated medical plans should accurately reflect expenses for medical education, training and research. (The Impact of Managed Care on Medical Education and Physician Workforce, ACP 96; revised BoR 08)

SUNSETTED