

Medicare Managed Care

How To Ensure Quality

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MEDICARE MANAGED CARE: HOW TO ENSURE QUALITY

Recommendations of the American College of Physicians Task Force on Aging

by
Michael J. Werner, JD

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Introduction

As a result of market forces and government policy, more and more Medicare beneficiaries will be enrolled in managed care plans. The ACP Task Force on Aging (the Task Force), does not oppose this development because older persons can benefit from the continuity of care, case management, and availability of preventive benefits often associated with managed care. The Task Force recognizes that managed care is a key long-term delivery system reform that has the potential to preserve the financial integrity of the Medicare program while providing older Americans with high quality and cost-effective care.

As with the under-65 population, however, the growth of managed care for Medicare beneficiaries could mean a reduction in the quality of care received by patients.¹ Internists are in a unique position to judge the quality of care provided to Medicare beneficiaries. Internal medicine is the only specialty that requires its residents to undergo training in geriatrics.² Moreover, most internists become experts in caring for Medicare beneficiaries because such a large percentage of their patients are over 65.

Consequently, the Task Force, from its perspective as a group of internists and geriatricians, has developed the following set of recommendations designed to ensure that the evolving system meets the needs of older patients served by the Medicare program. These quality standards for managed care organizations (MCOs) serving the elderly will require that MCOs recognize that older patients have different problems and health needs than the rest of the population, and that therefore, they must establish appropriate policies, procedures, and standards to care for them.

Specifically, the Task Force recommends that:

- **a new set of quality indicators -- developed specifically for the Medicare population -- be used to determine whether a plan is providing appropriate continuity and coordination of care;**

- **managed care plans not currently serving older persons should be required to modify their existing policies and structure before enrolling Medicare beneficiaries;**
- **Medicare MCOs 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;**
- **an MCO'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;**
- **MCOs should be required to regularly perform surveys to determine patient and physician satisfaction;**
- **case-by-case review should be eliminated and replaced with a system of ongoing monitoring of practice patterns, quality improvement, and outcomes;**
- **Medicare MCOs should be required to provide HCFA with the clinically relevant data from which valid quality indicators can be produced;**
- **MCOs seeking authority to participate in Medicare should be subject to rigorous marketing, selection, and enrollment standards;**
- **Medicare payments to MCOs should include risk adjusters or similar methodologies that adjust payment rates based on the health status of enrollees;**
- **Funding should be provided for research on outcomes and to develop quality measures;**
- **Medicare MCOs should be required to provide a set of preventive benefits.**
- **Integrated delivery systems including physician-run plans and physician-hospital organizations (PHOs) should have the authority to contract directly with HCFA to serve the Medicare population.**

Background

Under current law, Medicare beneficiaries have the option of enrolling in a managed care plan, and about 9% of the Medicare population (over 3 million people) have already done so. It seems clear that this trend will continue. Government policy, as well as market forces and HMO penetration throughout the country will mean that more and more

Medicare beneficiaries will be in managed care plans. In fact, Medicare HMO enrollment increased 20% last year.³

Some observers believe that quality of care will suffer as managed care proliferates in the Medicare population. Given the historical problems with some Medicare HMOs,⁴ as well as the incentives within managed care to limit access to services,⁵ they say, the spread of managed care raises concerns about whether older Americans will continue to receive high quality care. Moreover, while many believe that physician-run health plans can provide higher quality care to their enrollees than insurer-sponsored managed care organizations (MCOs),⁶ they are concerned that these traditional plans will dominate the market.

In contrast, many experts argue that Medicare beneficiaries could benefit from managed care. Because of their often complex conditions, a system structured to provide coordinated care and case management would provide this population cost-effective and appropriate care. In addition, managed care's traditional focus on preventive care would provide the elderly with services that might prevent hospitalizations or the development of more serious conditions.

On balance, research data supports the contention that quality of care in managed care environments is comparable to fee-for-service. For example, the evaluation of the Medicare Risk Program for HMOs performed for the Department of Health and Human Services concluded that "for the most part, Medicare HMOs appear to deliver care that is neither better nor worse than that rendered in [fee-for-service], either for hospital or ambulatory care."⁷ This finding is consistent with earlier research that found little or no evidence that the quality of care -- either defined as health outcomes or access to care -- for HMO enrollees or fee-for-service patients differed noticeably.⁸ On the other hand, in at least one study, HMOs have been shown to have a slightly negative effect on outcomes for certain conditions.⁹

These findings are consistent with the literature on quality of care in managed care for the under-65 population. For example, the Medical Outcomes Studies have shown that patients (elderly and non-elderly) in managed care have similar health outcomes as those in fee-for service.¹⁰ In addition, after an extensive review of literature, Miller and Luft concluded that HMO and indemnity plans provided enrollees with roughly comparable quality of care, according to process or outcomes measures.¹¹

Medicare HMOs also generally receive high scores on patient satisfaction. Specifically, Medicare HMO enrollees have expressed greater satisfaction than their fee-for-service counterparts with their out-of-pocket expenses.¹² Moreover, in a survey of Medicare beneficiaries, the great majority of enrollees in Medicare risk HMOs believed they got the Medicare services they needed.¹³ However, other studies have shown that although overall satisfaction with services was high, on certain aspects of the quality of care they receive, patient satisfaction is somewhat less for Medicare enrollees in HMOs than for those in fee-for-service.¹⁴

Thus, the literature published to date indicates that in general, the elderly will not face an inherent quality problem simply by enrolling in a managed care plan. However, some quality problems have been identified. Moreover, the aggregated evidence of managed care quality does not mean that every Medicare HMO will be providing high quality care. For example, a recent survey of Medicare beneficiaries found that many Medicare risk HMOs were out of compliance with federal standards, raising questions about the quality of care they received. In that survey, 43% of beneficiaries said they were asked at application about their health problems, and 25% said they did not know they had the right to appeal the HMOs' refusal to provide or pay for services.¹⁵

In addition, existing quality assurance mechanisms designed to protect Medicare beneficiaries may be flawed. A recent government report found that HCFA's process for monitoring and enforcing quality standards is limited.¹⁶

These problems could become exacerbated as new MCOs organize or as organizations aggressively try to tap into a new Medicare market. Many of these organizations have little or no experience with the elderly, and therefore may not be able to adapt their structures to care for them. Moreover, since the elderly use more services than the non-elderly, this could create cost pressures for the MCO.

Another potential problem could be that as managed care plans flourish in the Medicare market, more of their enrollees will be newcomers to managed care. Since Medicare beneficiaries currently enrolled in managed care plans are healthier, perceive their health status as better and are less likely to use health care services when they are sick than non-enrollees,¹⁷ it is also likely that these new enrollees will be older and sicker.

In addition, while managed care organizations may ultimately compete on quality, in the short term it appears that cost will be the primary reason for consumer selection. With this focus on costs, quality standards are essential. Moreover, reduction in hospital costs is often a focus of managed care cost cutting. Since the Medicare population uses more hospital services than younger patients, this has important implications for the quality of care these patients receive.

The evolving Medicare managed care market also must successfully integrate a range of services to meet the needs of older patients. Such integration requires the active involvement of the delivery system -- not arms length insurance arrangements "managing care" through regulatory techniques. Therefore, to ensure that older persons receive cost-effective and high quality care, it is essential that the delivery system be changed to reduce demand by emphasizing prevention, continuity of care, case management, and the use of functional outcomes and quality indicators designed specifically for the Medicare population.

For these reasons, the Task Force recommends that quality standards be developed for MCOs serving the Medicare population. They should be designed to ensure that MCOs recognize the different health needs and conditions of older persons, and establish the

appropriate policies for caring for them. Physicians should be involved in the development of these standards.

Integration of Services/Continuity of Care

Provision of Care

Since Medicare beneficiaries could benefit from the coordination and continuity of care that results from integration, organizations seeking to serve this population must be able to provide care in this manner.

Under current law, a Medicare HMO/CMP must ensure that services are available and accessible in a manner that assures continuity. Continuity is shown, in part, by the coordination of services among primary and specialty care physicians and the coordination of ancillary services including social services, home care, as well as physical and occupational therapy. The implementing manual notes that continuity can be achieved by having a primary care physician responsible for coordinating overall health care.

The Task Force recommends that to participate in Medicare, health plans should be required to demonstrate how they have taken into account the special needs of older patients in developing mechanisms to coordinate care. Consequently, the Task Force recommends that a new set of indicators -- developed specifically for the Medicare population -- be used to determine whether a plan is providing the appropriate continuity and coordination of care. These indicators are:

- access to the full spectrum of geriatric services, including long-term care, home care, and case management;
- documentation of a comprehensive geriatric assessment that includes an initial and follow-up screening for functional status using a checklist of activities of daily living and instrumental activities of daily living, availability of social support, as well as screening for depression and dementia;
- verification of the use of multi-disciplinary provider teams headed by a primary care physician;
- assured access to care that recognizes the functional limitations of the elderly; and
- geriatric pathways and practice guidelines for the elderly to manage identified syndromes.

In addition, some mechanisms currently used by health plans to coordinate care for younger patients might be inappropriate for the elderly. Consequently, managed care plans that currently do not serve the elderly should be required to make the necessary modifications before enrolling Medicare beneficiaries.

In particular, there must be a recognition of the limitations of older patients. These limitations can be logistical such as inadequate access to transportation, or health status related such as poor vision and hearing which hurts the patient's ability to understand

communications from the health plan including those that describe enrollment procedures, appeal rights, benefits, and other important information.

Education and Training of Physicians

Since the best way for a health plan to provide high quality and cost-effective care for the elderly in a managed care environment is to properly train its physicians, the Task Force recommends that Medicare HMOs/CMPs be required to continuously train their physicians and other health care professionals in geriatrics. Specifically, plans should train their physicians in concepts of coordinated care that use a multidisciplinary team. Since reimbursement for graduate medical education is already a component of the capitated payment Medicare HMOs receive, this requirement is not burdensome.

Medicare HMOs/CMPs should be required to demonstrate that their providers receive ongoing training and education in how to provide integrated care for the elderly population through conferences, CME, specific courses, or board review. In particular, because of the special needs of the "frail elderly", as well as the high cost of caring for them (this subset of the elderly represents only about 15-20% of the elderly, but accounts for about 80% of Medicare spending), managed care organizations should educate their physicians to help them recognize frailty and take the appropriate steps to prevent further functional decline. They should give special attention to geriatric syndromes and the diseases with a high prevalence in the elderly population. In addition, health plans should develop and use special practice guidelines for older patients, and should perform outcomes studies and use CQI methods to improve performance.

A model is a program developed jointly by the Tufts Medical School and Tufts Health Plan. Physicians, residents and medical students participate. The health plan will study patient outcomes and satisfaction with treatment, as well as costs. The plan will use this information and continuous quality improvement methods to educate the physicians (and students) about how to improve care and contain costs.

Internal Quality Review

Under current law, Medicare HMOs/CMPs must meet certain quality assurance standards. In particular, the law requires an internal quality review program that, in part, stresses health outcomes and uses systematic data collection of performance and patient results, and provides for review by physicians and other health professionals of the process of providing health services.¹⁸

The Task Force recommends that the provisions for review by physicians and the data collection and profiling should include a specification that they be based, to the extent practical, on reviews of outcomes and criteria derived from practice guidelines. Moreover, certain indicators should be used to illustrate that the plan's quality assurance system made appropriate use of outcomes and best practices for the elderly. These criteria

are particularly important because they will provide information about quality rather than only costs.

For example, vaccination rates, mammograms, hemocult/rectal exams, and knowledge of advance directives are outcomes that could easily be measured. In addition, criteria for data collection and interpretation to change practices should emphasize preserved or improved functional status and patient satisfaction. Another good rule of thumb could be that the percentage of quality indicators should be roughly equal to the percentage of elderly enrolled in the plan.

Moreover, the College recommends that health plans perform surveys to determine physician satisfaction. Research has shown that diminished physician satisfaction hurts patient outcomes.¹⁹ Thus, publicly disclosed physician satisfaction data would provide clues about the physician-patient interaction, and the quality of care patients receive.

External quality review

Many of the recommendations contained in the ACP policy on quality improvement and assurance developed last year are applicable to Medicare managed care. For example, the College recommends that case-by-case review be eliminated and replaced with a system that relies on physician profiling and quality improvement.²⁰ The centerpiece of this effort is the Quality Improvement Foundation (QIF), a private, non-profit entity whose mission is to provide ongoing quality monitoring and promote community-based quality improvement. The QIF would engage health plans, physicians, and other practitioners in collaborative efforts to improve care by monitoring patterns of care to identify successes and opportunities for improvement, as well as interpreting and sharing information about care processes and outcomes.

The Task Force re-emphasizes the College's recommendation on the creation of QIFs. Particularly as more Medicare beneficiaries enroll in managed care plans, ongoing quality monitoring and improvement programs are critical. Moreover, current law must be changed to require any MCO participating in Medicare to provide encounter data to the QIF, as fee-for-service plans do. Since there is currently no such requirement, the existing Medicare PROs' efforts at quality oversight have been greatly hindered. It seems clear that it would also severely restrict the ability of the QIF to perform its functions.

In the private sector, the National Committee for Quality Assurance (NCQA) has taken the lead on developing quality measurements for managed care plans. With the support of several employers, the NCQA has developed a set of measurements called the Health Plan Employer Data and Information Set (HEDIS). It is designed so employers can determine the quality of the health plan they purchase for their employees. The measurements will be turned into "report cards" to further enable plan comparisons. HCFA is currently working with the NCQA and other parties to apply HEDIS measures to Medicare beneficiaries.

HEDIS shows promise and is a major step forward. It has demonstrated that performance reports can be developed for many health plans, and provided insights into what must be done to advance the development of performance reports.²¹ Nonetheless, as it exists now, many observers have noted problems. These include difficulty in retrieving valid health plan data because of a variation in plan data systems and the complexities of risk adjustment. Moreover, HEDIS, like other report cards, measures processes believed to illustrate quality, rather than measuring health outcomes of patients.²² In addition, many observers have noted that the lack of encounter data from managed care plans diminishes the validity of the information contained in report cards.²³

Consequently, the Task Force recommends that Medicare HMOs be required to provide HCFA (or its designee) with the clinically relevant data from which it can produce valid quality indicators. This data should include information to determine: access to care; coordination of care; health outcomes; and patient satisfaction. Moreover, the Task Force supports the development of federal standards for this data to ensure uniformity and comparability among health plans. The data should be audited and verified by HCFA (or its designee) and published in an understandable format so consumers can compare plan performance. Prior to the auditing and publishing of this information, MCOs should be prohibited from using it in their marketing materials.

On a related matter, MCOs seeking authority to participate in Medicare should be subject to rigorous marketing, selection, and enrollment standards. Moreover, Medicare payments to MCOs should include risk adjusters or similar methodologies that adjust payment rates based on the health status of enrollees. Data has shown that there is a tremendous amount of favorable selection in Medicare HMOs.²⁴ That is, Medicare HMO enrollees tend to be healthier than those in fee-for-service. While one explanation of this phenomenon is that patients with chronic illness are more likely to maintain individual physician relationships, another is that HMOs actively engage in behavior to encourage favorable selection.

In addition, the Task Force recommends additional funding for research on outcomes and to develop quality measures. In prior years the Congress has provided money for these initiatives, primarily through the Agency for Health Care Policy and Research. With the prospect of federal budget cuts, however, it may be necessary to find new sources of revenue for this critical research. With the increase in managed care enrollment, developing this "technology" must be a priority.

Preventive Care

Studies have shown that adding a preventive benefit of a primary care physician visit to Medicare will provide beneficiaries with a modest health benefit, without a negative cost impact.²⁵ Some researchers have noted that this benefit will also improve communication between physicians and elderly patients and thereby improve decision-making about treatment.

Other preventive services have also been shown to save money. For example, Fiebach showed that immunizations would decrease influenza and pneumonia and subsequent health costs.²⁶ This was supported by Medicare claims data from West Virginia that indicated that hospitalizations from these illnesses cost \$75 million and that hospital treatment for complications cost an additional \$215 million. In contrast, vaccinations for flu and pneumonia would cost only \$7 and \$20 respectively.²⁷

Thus, additional preventive health benefits will improve health outcomes for the Medicare population. Although most Medicare HMOs have chosen to provide some of these benefits, the Task Force recommends that as a condition of participation, Medicare MCOs be required to provide a guaranteed set of preventive benefits. These should include, but not be limited to an annual visit to a primary care physician and immunizations.

Physician plans

As noted, the Medicare population would benefit from an integrated delivery system model. The Task Force believes that physician-run plans can provide these services more effectively than a traditional insurer-based MCO. Consequently, the Task Force recommends the following to facilitate the growth of physician plans in the Medicare managed care market:

1. Physician-run plans and Physician Hospital Organizations (PHOs) should have the authority to contract directly with HCFA to serve the Medicare population. While rules governing solvency and capitalization should be appropriately modified for physician-run integrated delivery systems, these networks should be required to comply with the relevant quality standards in existing law and described in this paper.
2. State licensure requirements that require an organization to be an insurer-sponsored HMO should be waived.
3. The so-called "50-50" rule should be modified.
4. A separate certification process should be established for physician-run plans. This will help ensure faster resolution of their application.

Conclusion

In sum, the Task Force believes it is critical to enact a series of policies to ensure that the quality of the care provided to Medicare beneficiaries in managed care environments remains high. Existing quality standards should be modified and new quality standards should be developed to take into account the special health needs and conditions of the elderly. In addition, case-by-case review should be eliminated and replaced with a system of practice pattern analysis and quality improvement based on data from outcomes research. Moreover, physician-run health plans should have the authority to contract directly with HCFA. The enactment of these proposals will go a long way toward making

sure that managed care will reach its potential and provide older Americans with high quality and cost effective care.

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