Statement to the Ways and Means Committee

for the record of the March 6, 1997 hearing

on

Medicare HMO Regulation and Quality

Introduction

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation's largest medical specialty. Internists provide care to more Medicare patients than any other specialty. With the rapid growth in beneficiary enrollment in Medicare managed care, internists increasingly are providing services to their patients through arrangements with Medicare HMOs and other managed care arrangements.

ASIM believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsideration of denied claims are heard in a timely manner.

Increased Enrollment Requires Increased Oversight

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 14 percent of beneficiaries belong to a Medicare managed care plan. The CBO projects that the share of total Medicare outlays that goes to HMOs and other Medicare managed arrangements will increase from 9.4% in FY 1996 to 32.9% in FY 2007--even without enactment of additional incentives for beneficiaries to enroll in managed care.

With increased enrollment, there is an increased need for the federal government to exercise appropriate oversight over the care provided to Medicare beneficiaries who are enrolled in MCOs.
Recent reports from the Institute of Medicine, the General Accounting Office (GAO), and the PPRC all support the need for improved standards for health plans that contract with Medicare. In its 1996 report to Congress, the PPRC recommended that all health plans that contract to provide services to Medicare beneficiaries meet standards relating to quality, access, disclosure of information and due process.
The GAO, in a recent report titled "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance" supports ASIM's views that HCFA needs to do more to implement measures that will enable beneficiaries to make an informed choice of plan. The GAO concluded that HCFA can readily provide indicators of beneficiary satisfaction and other plan-specific information, including statistics on beneficiary disenrollments and complaints, medical loss ratios (the percentage of HMO revenues spent on medical care) and other financial data, and visit monitoring results. The percentage of claims that are appealed to HCFA, and then reversed or upheld upon appeal, is another indicator of HMO performance that can immediately be made available to beneficiaries.

Although HCFA plans to require a standardized beneficiary satisfaction survey "beginning with the upcoming calendar year, " the GAO expressed concern that HCFA has no plans to provide this information automatically to beneficiaries, and that the comparison chart that HCFA plans to develop will be available only through the Internet--a forum that may not be easily accessible to most Medicare beneficiaries. We agree with the GAO's conclusion that HCFA should provide comparative information on each plan directly to beneficiaries.

ASIM's Recommendations

In August, 1996, ASIM released a policy paper titled "Re-Inventing Medicare Managed Care: Improving Choice, Access and Quality." The paper presents a detailed and comprehensive set of proposals for improving the comparative information that is available to beneficiaries; for assuring adequate access to physicians and other needed services, especially for patients with special needs; for streamlining and improving the appeals process; for incorporating risk adjustments into the payments to HMOs; for expanding the types of plans available to beneficiaries; for assuring adequate physician and patient involvement in developing health plan standards and protocols; for external oversight of HMO quality; and for providing due process for physicians who are "de-selected" by a plan. We would be pleased to provide the entire paper to the subcommittee.

At a minimum, ASIM urges the subcommittee to report legislation that would:

1. Direct the Secretary to mandate that Medicare MCOs disclose to current and prospective enrollees and providers information needed to make an informed choice of plans, including:

> A. Requirements that limit access to services (i.e. extent to which enrollees may select the provider of their choice, restrictions that limit coverage to prescription drugs approved by the MCO, and rules that limit access to laboratory tests in physicians' offices);
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> B. Indicators of health plan quality, access, and patient satisfaction (including disenrollment rates; number and percentage of claims that were denied and then reversed upon appeal to the Secretary; the MCO's medical loss ratio--defined as the proportion of total revenue spent on medical care, as opposed to administrative expenses or funds retained or distributed to owners; and the results of standardized patient satisfaction surveys).

In the report cited above, the GAO found that beneficiaries often are unaware of the restrictions on access to certain services that are typically required by MCOs. Disclosure of such restrictions will enable beneficiaries to make a more informed choice of plans, and will reduce subsequent misunderstandings and dissatisfaction. Information on disenrollment rates, claims denials, and medical loss ratios can be useful indicators of the quality of care rendered with a plan. HCFA has begun to provide beneficiaries with more information but its efforts to date fall short of providing the kinds of information discussed above.

2. Mandate that Medicare MCOs review pre-authorization requests for urgent care services within one hour and all other pre-authorization requests within 24 hours. Direct the Secretary to streamline the appeals process for denials by Medicare MCOs by reducing by half the days that MCOs are allowed to consider an appeal of an initial denial.

Although the administration has stated that it intends to make changes in the appeals process to provide more timely determinations on denials of care by Medicare MCOs, it is our understanding that the administration's proposal will not go far enough in assuring timely rulings on pre-authorization requests, and in reducing the amount of time that MCOs have to rule on appeals of initial denials. According to the GAO and the PPRC, MCOs are currently given up to 60 days to make their initial determination. They have another 60 days to decide on an appeal of the initial determination--a total of four months when patients are effectively being denied access to care that they and their physician believe to be necessary. Cases that require HCFA review can take even longer--sometimes up to 270 days. Further, GAO found that MCOs and HCFA's own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

We understand that HCFA is now under a court order to make specific improvements in the appeals process. ASIM is pleased by this decision, particularly the requirement that HCFA assure that plans do not retaliate against physicians who help enrollees appeal a denial by a Medicare managed care plan. HCFA has not yet indicated if the decision will be appealed. ASIM believes that it would be helpful for Congress to step in and provide specific legislative direction on improvements in the appeals and grievance processes.

3. Mandate that Medicare MCOs establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians into the medical policies, medical management, utilization review, and quality and credentialing policies and criteria developed by the MCO.

Physician involvement in establishing managed care policies that have a direct impact on clinical decision-making is essential if patients are to have confidence in their HMO. Rather than attempting to legislate the lengths-of-stay for given procedures, it would be far better to mandate a process that would assure that managed care plans do not adopt restrictions on coverage that lack the support of the physicians who are ultimately responsible for patient care.

4. Mandate that HCFA immediately incorporate risk adjustments into payments to HMOs.

The President's budget proposes that the average adjusted per capita cost (AAPCC) be reformed by (1) setting local rates at 90 percent of the prevailing fee-for-service rates, rather than 95 percent under current policy (2) subtracting graduate medical education payments and disproportionate share hospital payments from the AAPCC and instead giving them directly to the institutions incurring the costs and (3) lowering the AAPCC in certain high cost areas and increasing them in low cost areas.

ASIM has no specific policy on the proposal to lower payments from 95 percent to 90 percent of the prevailing fee-for-service rates. Given that the CBO projects that outlays on Medicare HMOs will increase at an average rate of 71 percent per annum, it is reasonable for the Congress and the administration to review ways to achieve savings in this category of spending, especially if this will reduce the need to further slash fee-for-service payments. Although not conclusive, there are some studies that suggest that Medicare HMOs do enroll a healthier patient population than the fee-for-service program, and that the current formula may on average overcompensate HMOs for the care of the healthier patients that they typically enroll. ASIM also supports the goal of reducing geographic inequities in AAPCC payments, but we have not yet determined if the administration's proposal is the best way to correct such inequities.

ASIM is concerned that in the absence of a risk adjustment for the AAPCC payments to HMOs, HMOs that treat a sicker mix of patients will be penalized, especially if the AAPCC rate is lowered to 90 percent from 95 percent. This would increase the disincentive for HMOs to enroll sicker patients. ASIM supports the PPRC's view that:

> regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, health plans will not be fairly paid for enrollees with better or worse-than-average status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for. The commission recommends that improved risk adjustment be implemented immediately.
> (Statement before the Subcommittee on Health, Ways and Means, on Medicare HMO Payment Policy, February 25, 1997)

Because internists tend to treat Medicare patients that are older and sicker than those of other physicians, ASIM believes that it is particularly important that Congress initiate payment reforms--including risk adjustment--for Medicare HMOs that would decrease the likelihood that internists' patients will be discriminated against by HMOs that are trying to limit their own risk.

5. Mandate the HCFA require that plans adopt a "prudent layperson" standard in making coverage decisions on emergency room denials.

Beneficiaries should not be financially penalized for seeking initial treatment in an emergency room when they have a reasonable basis to believe that they had a medical emergency, even if it is later determined that the condition was not life-threatening. ASIM supports H.R. 815, introduced by Reps. Ben Cardin and Marge Roukema and co-sponsored by several members of this subcommittee, including Reps. Stark, Levin, and McDermott, which would apply a "prudent layperson" standard not only to Medicare HMOs, but also to all group health plans and health insurance coverage.

Conclusion

ASIM supports major reforms in Medicare that would move the program toward a defined contribution model, similar to the Federal Employees Health Benefit Program. A defined contribution program would have to include major safeguards to protect beneficiaries, however, including defined minimum standards to hold all competing plans accountable for the quality of care, access to needed services, and physician and patient involvement in coverage standards and utilization review protocols. The defined contribution would have to be adequate to allow beneficiaries to choose from a wide range of plans that offer benefits at least equal to the current program.

Even in the absence of major restructuring along these lines, however, it is clear that the federal government can and should do a better job of holding Medicare HMOs and other managed care plans accountable to reasonable quality standards. The recommendations presented in this statement, and the more comprehensive set of proposals in our "Re-Inventing Medicare Managed Care" policy paper, would assure that the federal government exercises sufficient oversight over decisions by health plans that can affect quality and access, without stymieing innovation and market competition.

ASIM looks forward to working with the subcommittee on enacting appropriate quality and access standards for all Medicare managed care plans.