August 25, 2000

Ms. Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-1030-FC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Medicare+Choice Program; Final Rule
HCFA-1030-FC, RIN 0938-AI29; *Federal Register* Vol. 65, No. 126, June 26, 2000.

Dear Ms. DeParle:

The American College of Physicians−American Society of Internal Medicine (ACP−ASIM), representing 115,000 physicians who specialize in internal medicine and medical students, is pleased to offer its comments regarding the Health Care Financing Administration's (HCFA) Medicare+Choice (M+C) Program final rule published in the *Federal Register* on June 29, 2000.

As noted in our September 23, 1998 comment letter on HCFA's interim final rule on establishment of the M+C program published in the June 26, 1998 *Federal Register* (attached), ACP−ASIM is supportive of the M+C program because it gives Medicare beneficiaries a much wider array of health care delivery options. We still support this goal and new provisions in HCFA's M+C final rule (derived from the Balanced Budget Refinement Act of 1999) that strengthen the M+C program and beneficiary choice by: offering financial incentives ("new entry bonus payments") for plans to enter new service areas, extending Medicare cost contracts an additional two years (through December 31, 2004), making it easier for beneficiaries to continue in the M+C program even if the M+C plan they are enrolled in terminates, absolving institutionalized individuals from M+C plan lock-in requirements when these take effect on January 1, 2002, and reducing the waiting time for terminated plans to reenter the M+C program (from five years to two years).

The comments which follow focus on the degree to which the M+C final rule address the seven major areas of concern identified in our September 28, 1998 comment letter to HCFA, as listed below.

(1) The need to keep the M+C program from becoming a bureaucratic burden on physicians, other health care professionals, and managed care organizations.

ACP–ASIM Comments: Overall, the final rule appears to provide a mixed impact wherein the regulatory burden is decreased in some areas (such as deletion of mandatory reporting of credible information on violations of the law) and increased in other areas (such as collection of physician encounter data).

We are disappointed HCFA has not removed its requirement to collect user fees from M+C organizations to pay for the costs associated with the enrollment and information distribution activities of the M+C program and the health insurance counseling and assistance programs required by the Omnibus Budget Reconciliation Act of 1990. These fees will simply be passed on to physicians and other health care professionals in the form of lower reimbursement. We feel strongly that operational functions carried out by HCFA, such as the M+C beneficiary education campaign, should be funded from the Medicare budget, not from a tax on physicians and other health care professionals.

Regarding HCFA's plan to collect physician encounter data for the purpose of risk adjusting M+C capitation rates, we reiterate our concerns on this subject sent to you in a letter dated June 9, 2000. First, although we understand HCFA's logic for implementing a full risk adjustment methodology for M+CO capitation rates, specifically, to encourage M+COs to enroll and treat sicker patients by increasing capitation amounts paid for such patients, we are concerned that there is no assurance that this incentive will be passed on to M+CO physicians. Does HCFA have a plan to assure physicians who treat sicker M+CO patients receive the full benefit of the enhanced capitation payments paid to the M+CO for these patients? If not, we are greatly concerned that physicians might be placed at significant financial risk for treating such patients, and possibly be forced to provide care at a loss. This would certainly be counter to HCFA's objectives, and could ultimately compromise access and quality of care for those patients most in need.

Second, we are concerned that the collection of physician encounter data may place an undue administrative burden upon M+CO physicians. Though HCFA is only mandating that M+COs submit the limited data which appears on the abbreviated HCFA-1500NSF, it is not clear whether or not they will transfer the burden of collecting this data to their physicians. It would be fine if M+CO physicians were permitted to continue to submit claims in whatever form is already accepted by their respective M+COs; however, if they are required to modify their manner of reporting/claiming in any way, this might create extra work for physicians and reduce time available for patient care. We thus urge HCFA to make collection of physician encounter data as simple and seamless as possible.

(2) The need for HCFA to distinguish between physicians, other health care professionals, and health care facilities.

ACP–ASIM Comment: The final rule did not address our concern that the M+C regulations characterize all health care professionals and facilities as "providers." Medicare historically has clearly distinguished between physicians, other health care professionals, and facilities. Using the term "provider" will create unnecessary confusion because it has so many potential meanings. To avoid such confusion, we urge HCFA to make this clear distinction in a technical correction to the final rule, and to also clarify that the term "physician" only be used in reference to a medical or osteopathic physician. Other health care professionals should be identified by their specific profession (i.e., chiropractor, dentist, optometrist, or podiatrist), or as "other appropriate health care professional."

(3) The need to ensure that beneficiaries are well informed of their choices and rights under the M+C program.

ACP–ASIM Comments: HCFA has done a good job of informing beneficiaries of the comparative benefits, rights, and privileges of M+C enrollment versus remaining in Medicare fee-for-service through its "Medicare and You" publication, its Medicare Choices 1-800-Medicare toll free help line, local outreach events, the State Health Insurance Assistance Program, and providing comparative information on local M+C plan choices on its "www.Medicare.gov" website. However, we still have a concern that beneficiaries do not always have current information on which physicians participate with each M+C plan in their service area. Also, it is also vital that a beneficiary wishing to change M+C plans be informed that his/her original plan physician may not be a participant and thus may be unavailable in the new plan. This point is not explicit in the latest version of "Medicare and You;" we would urge HCFA to make it so in this document's next revision, as well as in any M+C plan materials it approves for distribution to beneficiaries.

(4) The need to provide sufficient protections for beneficiaries to ensure they receive required services from their M+C plans, including appeal rights when services are denied, and adequate notice of M+C plan termination.

ACP–ASIM Comments: ACP–ASIM, in its September 28, 1998 comments on the M+C interim final rule, was generally supportive of HCFA's beneficiary protection provisions, though we suggested a few refinements that should strengthen these protections. One was to add a requirement to the expedited appeals mechanism that would result in an automatic favorable decision for the appealing enrollee if the M+C plan or external review organization arbitrating the decision does not render its decision within the 72 hour time limit. A second would be to add a requirement that M+C plans to disclose to beneficiaries their procedures for termination of physicians

and other plan health care professionals. We continue to urge HCFA to add these important patient protections.

We also urge HCFA to standardize its M+C plan requirements for notifying enrollees of physicians who are terminating their contract with the plan. Specifically, we

would like to see HCFA apply its M+C plan notification requirements for specialist terminations to all physicians—that beneficiaries be informed at the time of termination of their right to maintain access to specialists and be provided with the names of other M+C plans in the area that contract with specialists of the beneficiary's choice, as well as an explanation of the process the beneficiary would need to follow should he or she decide to return to original Medicare.

(5) That M+C plans have an ongoing quality assessment and improvement process that is not overly burdensome.

ACP–ASIM Comments: We are generally supportive of the statutory requirement that all M+C plans have an ongoing quality assurance program, as specifed under 42 CFR 422.152 ("Quality Assessment and Performance Improvement" requirements--QAPI). Specifically, this regulation requires that each M+C plan maintain a health information system that collects, analyzes, integrates, and reports data to support the measurement of performance levels and the conduct of performance improvement projects.

We are pleased that the final M+C rule addresses our concern that meeting QAPI requirements would be burdensome and unrealistic for certain types of M+C plans—non-network Medical Savings Account plans, Private Fee-for-Service plans, and Preferred Provider Organization type coordinated care plans. The final rule recognizes that the fact that the provider networks of these types of M+C plans are subject to a lesser degree of control and accountability, absolving them of the requirement to conduct performance improvement projects, or to have to meet minimum performance levels.

We still have concern that HCFA's requirement that M+C coordinated care plans conduct two new performance improvement projects each year could be overwhelming and overrun physician offices with data collection requests for information that is not central to patient care. We would thus urge HCFA to reconsider reducing this requirement one new project per year until the impact of this workload on M+C plans and their physicians can be better assessed.

(6) That HCFA add a provision which formalizes a committee structure for assuring physicians' input into a M+C plans' credentialing policy, medical policy, quality assurance program, medical management procedures, practice guidelines, and utilization management guidelines.

ACP–ASIM Comments: : We appreciate HCFA's direct consideration of, and response to, our recommendation presented on page 40235 of the June 29, 2000 *Federal Register's* publication of the M+C final rule (42 CFR 422.202(b)—"Consultation Requirements." It is clear HCFA agrees that direct, formalized
physician input in the above areas is a vital element in guiding an M+C plan's policies and operations. Though we still feel a committee structure would be the most viable means of assuring this input, we accept HCFA's goal of extending maximum flexibility to M+C plans

in how they obtain this input by adding language that these organizations must "establish a formal mechanism" for consulting with plan physicians.

(7) That HCFA add a provision which clarifies that physicians and other health care providers who adhere to a M+C plan's utilization protocol not be held responsible for denying medically necessary care if the denial occurs as a result of adhering to a M+C plan's utilization protocol.

ACP–ASIM Comments: This recommendation appears to be partially addressed in the final rule's discussion (on pages 40277-40278 of the June 29, 2000 *Federal Register*) of when M+C plans must provide beneficiaries formal written notice of a discontinuation of service. HCFA states that "if an M+C organization discontinues coverage, and an enrollee indicates that he or she believes the services continue to be necessary, this action would constitute an organization determination for which a written notice must be provided." This seems to place responsibility for a denial of continued coverage on the M+C plan, not the physician, but not in the explicit manner we would prefer. However, we do note that HCFA is now developing language for a standardized notification practitioners would use to routinely inform enrollees of their right to receive a detailed notice about their services from the M+C organization, and all information necessary to contact the M+C organization (presumably their right to appeal a denial decision and the process to be followed). HCFA indicates the public will have an opportunity to comment on this standardized notification through the Office of Management and Budget's Paperwork Reduction Act. In developing this notification form, we would urge HCFA to include language which specifically absolves physicians of responsibility/liability for denial decisions that result from application of their M+C plan's utilization criteria.

Conclusion

ACP–ASIM believes the goal of the M+C program, to optimize beneficiary health care options, is a worthy one, and that the final M+C regulations are supportive of this goal. Our comments seek to bring greater clarity and specificity to selected sections of the final M+C rule, and we hope they are duly considered by HCFA in any forthcoming technical corrections or M+C related guidances.

Please contact Mark Gorden, Senior Associate for Managed Care and Regulatory Affairs, at (202) 261-4544 if you have any questions concerning this correspondence.

Sincerely,

Cecil B. Wilson, MD, FACP

Chair
Medical Services Committee

Attachment