

September 23, 1998

Nancy-Ann DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 309-G
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: HCFA-1030-IFC RIN 0938-AI29

Dear Ms. DeParle,

On behalf of the American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing the nation’s largest medical specialty, I am writing to comment on the Health Care Financing Administration’s (HCFA) interim final rule on the establishment of the Medicare+Choice Program, published in the June 26, 1998 *Federal Register*.

ACP–ASIM supports the creation of the Medicare+Choice (M+C) program because it will give Medicare beneficiaries the opportunity to choose to receive their health care benefits from a wider variety of health care delivery options. ACP–ASIM is generally pleased with HCFA’s new patient and health professional protection provisions. However, we caution HCFA to be vigilant in assuring that Medicare beneficiaries continue to receive high quality service and to protect against an even greater Medicare hassle factor. Other issues contained in these comments include: definition of provider; beneficiary information; beneficiary protections; quality; organizational relationships; and limitations on provider indemnification.

Hassle Factor

ACP–ASIM is concerned that the Medicare+Choice program may become a bureaucratic burden on physicians, other health care professionals, and managed care organizations. We do not support user fees of any sort, including the fees assessed to managed care organizations to support the beneficiary education campaign. These fees will simply be passed on to physicians and other health care professionals in the form of lower reimbursement. Operational functions carried out by HCFA, such as the Medicare+Choice beneficiary education campaign, should be funded from the Medicare budget, not from a tax on physicians and other health care professionals.

While we understand the importance of quality assurance programs and the potential need for encounter data submission for quality and payment reasons, HCFA and the Medicare+Choice participating organizations must be very careful not to create an unnecessary paperwork burden for physicians and other health care professionals. These programs must focus on obtaining information that is essential for maintaining a quality managed care organization rather than

seeking to obtain information that may be interesting but non-essential. Data collection requirements can substantially increase the cost of providing care. Often data collection requirements do not recognize the increased work involved with providing such information.

Definition of Provider

We are concerned that the Medicare+Choice regulations characterize all health care professionals and facilities as “providers.” Medicare historically has clearly distinguished between physicians, other health care professionals and facilities that are responsible for the provision of health care services. Using the term “provider” will create unnecessary confusion because it has so many potential meanings. The Medicare +Choice regulation uses this term in a far broader manner than any other previous regulatory uses of the term. A careful review of the Medicare +Choice regulations and corrections to appropriately recognize the roles of physicians (as defined by Section 1861(r)(1) of the Social Security Act), other health care professionals and health care facilities throughout the regulations are needed. Also, the term “physician” should be used only where the reference is 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.”

Beneficiary Information

ACP–ASIM supports HCFA’s decision not to address the physician-patient relationship aspect of the beneficiary information/education campaign. While ACP–ASIM shares HCFA’s concern that unscrupulous providers may attempt to steer patients to managed care organizations with which the provider has a financial interest, we believe that incidences of steering will be very rare. The physician-patient relationship is built upon a foundation of trust that should not be needlessly interfered with. It would be far more damaging to patients if they sought information from their physician regarding their new Medicare+Choice options and the physician couldn’t respond because of a government gag order. HCFA should continue to work with physicians and other health care professionals to develop standards that suggest appropriate and inappropriate mechanisms for physicians to share information with their patients regarding the Medicare+Choice program, to protect the patients from unscrupulous health care professionals, and protect physicians from inappropriate fraud and abuse investigations.

Beneficiaries should be provided more timely and accurate information regarding participating physicians in Medicare+Choice plans. We recently received a complaint from one of our members that a plan in Texas was consistently providing inaccurate physician panel information to patients seeking to enroll with the plan. When patients asked if the doctor in question was in the plan, the plan responded that they had a doctor with the same last name. However, upon further investigation, it turned out not only to be a different physician but a physician located in a different city as well. Physician directories are out-of-date almost from the instant they are printed; for this reason, patients must be able to access more current physician directory information through telephone contact with the managed care plan and through the Medicare Compare Internet web site.

HCFA must ensure that the patient is well aware that his/her current physician may not participate with a Medicare+Choice plan before the patient makes a change to a new Medicare+Choice plan. The primary care physician treating the patient must be notified of the patient's decision to switch to a new plan when the patient informs the plan as well. Whenever possible, specialty care physicians who are currently treating the patient must also be informed. Often, the physician is not informed or is informed only after the patient has been seen several times following changing to a different plan of which the physician is not a member. This means the patient is liable for the cost of care. Generally, collecting for services provided is then very difficult.

HCFA proposes to include a beneficiary warning that "an M+C organization may terminate or refuse to renew its contract or reduce the service area included in its contract" in its beneficiary educational materials. Since the departure of a patient's personal physician from the network could be just as devastating to some patients as the termination of the contract, HCFA should also include a warning about potential changes in M+C organizations' physician networks.

HCFA has established guidelines regarding approval of marketing materials. Once those materials are approved, there is no means of further patient protection. HCFA should clarify that the agency has the right to stop marketing material that is deemed inappropriate after initial approval.

HCFA intends to use a "public process to determine information and data specifications" for Medicare Compare. However, physicians and other clinicians are not listed as groups that HCFA plans to include in this collaborative effort. HCFA must ensure that physicians are intimately involved in determining data specifications for the plans. Clinical input is needed in the development of such specifications. Medical organizations have played a leadership role in developing performance standards and measurements thus far and should not be excluded from this effort. It is critically important to include the perspective of the people who collect and disseminate this information--physicians and their office staff.

Beneficiary Protections

ACP-ASIM supports the requirements that M+C organizations assume financial liability for emergency services, urgently needed services, renal dialysis services provided while the enrollee was temporarily outside the plan's service area, post-stabilization care services, and services denied by the M+C organization that are found, upon appeal, to be services the enrollee was entitled to have furnished or paid for by the M+C organization. HCFA's post-stabilization service coverage criteria are reasonable and appropriate patient protections. These criteria are: (1) pre-approval by the M+C organization; (2) pre-approval not obtained because the organization did not respond to the request by the provider of post-stabilization care within 1 hour after such approval was requested; and (3) the M+C organization could not be contacted for pre-approval.

ACP–ASIM generally supports the beneficiary appeal mechanism and time-frame described in the regulation. An improved appeal mechanism is perhaps the most important patient protection in the regulation. ACP–ASIM notes that HCFA has greatly improved the appeals mechanism in recent years, especially with the advent of the 72 hour expedited appeal mechanism. In order to ensure that the appeals process will be followed, the regulation should state that the case will be decided in favor of the beneficiary if the M+C plan or the Medicare contractor who arbitrates the appeal does not follow the appropriate appeals time-frame.

ACP–ASIM supports the requirement that upon enrollment M+C organizations must disclose to each enrollee clear, accurate, and standardized information on service area, benefits, access, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, grievance and appeals procedures, disenrollment rights and responsibilities, and information about the organization’s quality assurance program. ACP–ASIM supports the requirement that upon request M+C organizations must provide additional information on utilization control procedures, the financial condition of the organization, and a summary of physician compensation arrangements. M+C organizations should also be required to disclose their plan procedures for the termination of physicians and other plan health care professionals.

The M+C termination notification requirement for physicians is inconsistent and should be standardized. M+C organizations are required to make a good faith effort to provide written notice of a termination of a contracted provider within 15 days of receipt or issuance of a notice of termination to all enrollees who are patients seen on a regular basis by the physician whose contract is terminating and to all enrollees who are patients of a primary care physician who is terminated. The requirement for specialty physicians is stronger and preferable for all physicians. Under the preferred provision, M+C organizations must: (1) inform beneficiaries at the time of termination of their right to maintain access to specialists; and (2) provide 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.

ACP–ASIM supports HCFA’s plan to strengthen its ability to sanction M+C plans which do not follow Medicare regulations. As is noted in the American Society of Internal Medicine “Reinventing Medicare Managed Care” policy paper, HCFA must also use its sanctioning authority, when appropriate, to ensure that beneficiary protection is maintained and respected. Although HCFA has had sanctioning authority over managed care contractors, it has not opted to use its authority in the past.

Quality

ACP–ASIM supports an ongoing quality assessment and improvement M+C program under the Quality Improvement System for Managed Care (QISMC). While we understand that QISMC emphasizes measurement of health outcomes, consumer satisfaction, and accountability of managed care organizations for achieving quality improvement, QISMC regulations have not yet been issued, which makes the quality provisions in the regulation unclear. We also understand that managed care organizations are concerned that the implementation rate of two new

performance improvement projects each year is overwhelming. We are concerned that the rapid rate of implementation will overrun physician offices with data collection requests for information that is not central to patient care. While we support this type of quality improvement process, it is not appropriate to institute a process that has unrealistic expectations, which could lead to faulty implementation and create new hassles for physicians and other health care professionals.

The regulation to maintain a health information system that collects, analyzes, and reports data also is unrealistic, especially for non-network M+C Medical Spending Account plans and M+C private fee-for-service plans. This requirement will create an inordinate burden for the plans and their associated physicians, who will be responsible for data collection and reporting to the plans. Furthermore, M+C plans are unprepared to deal with the potential volume of data they would be required to collect, analyze, and report. There also is potential for increased duplication and administrative cost to the health care system if there are no uniform collection methods for HCFA and private accreditors who are requiring the similar information.

Organizational Relationships

ACP-ASIM strongly supports HCFA's goal of enhancing physician and other health care professionals participation and communication with M+C coordinated care plans regarding the organization's credentialing policy, medical policy, quality assurance program, medical management procedures, practice guidelines, and utilization management guidelines. However, HCFA's requirements need greater clarification. HCFA could improve these requirements by establishing a committee structure for M+C organizations to solicit input on various policies from participating and subcontracting physicians and other health care professionals. Each committee would focus on one of the issue areas mentioned above, such as practice guidelines or credentialing standards. By adhering to this structure, HCFA could ensure that physicians and other health care professionals not only have a meaningful voice in the policies that affect their participation in a particular M+C plan, but also the way they deliver health care services to enrollees. The membership of these committees should consist of participating physicians and other health care professionals representing a broad mix of specialties and geographical areas covered by the plans offered by the M+C organization. The M+C organization should delegate the responsibility of nominating individuals for committee membership to the individual physicians, other health care professionals, medical groups and independent practice associations (IPAs) with which it contracts directly, or through subcontracting arrangements.

Limitations on Provider Indemnification

ACP-ASIM supports the proposal to prohibit M+C organizations from requiring physicians, other health care professionals, and physician groups, indemnify them against any civil liability for damage caused to an enrollee as a result of the organization's "denial of medically necessary care." This prohibition recognizes that a managed care plan's refusal to authorize treatment sometimes results in harm to patients. However, HCFA should also include an organization's implicit denial of medically necessary care, which would recognize that damage can result from

a physician's adherence to a M+C plan utilization protocol that later might be viewed as a failure to deliver medically necessary care.

Conclusion

Thank you for full consideration of these comments. ACP-ASIM supports many of the provisions contained in the Medicare+Choice interim final rule. We believe that the beneficiary protections in the rule can be strengthened by implementing the recommendations mentioned in this statement. We are concerned about potential bureaucratic hassles that will arise due to data collection requirements in this program. ACP-ASIM will continue to monitor the M+C program and offer recommendations to further refine the program as it evolves.

ACP-ASIM appreciates the opportunity to comment on the Medicare+Choice Program interim final rule. If you have any questions regarding our comments, please contact the ACP-ASIM's Director of Managed Care and Regulatory Affairs, John P. DuMoulin, at (202) 261-4535 or <JDumoulin@mail.acponline.org>.

Sincerely,

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President