S. HRG. 104–876

SAFEGUARDING SENIORS HEALTH CARE: QUALITY IN MANAGED CARE

Y 4. AP 6/2: S. HRG. 105-876

Safeguarding Seniors Health Care: Q...

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

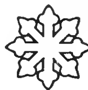
ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SPECIAL HEARING

Department of Health and Human Services
Nondepartmental witnesses

Printed for the use of the Committee on Appropriations



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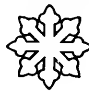

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SAFEGUARDING SENIORS HEALTH CARE: QUALITY IN MANAGED CARE

WEDNESDAY, NOVEMBER 13, 1996

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:30 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

NONDEPARTMENTAL WITNESSES

STATEMENT OF JOHN E. WARE, JR., Ph.D., SENIOR SCIENTIST, NEW ENGLAND MEDICAL CENTER

OPENING STATEMENT OF SENATOR SPECTER

Senator SPECTER. Good morning, ladies and gentlemen. Our hearing today focuses on managed care as it impacts on senior citizens and is part of our ongoing inquiry on the subcommittee on how to provide health care for all Americans.

With the passage earlier this year of the Kassebaum-Kennedy bill, we have taken a significant incremental step in covering many more Americans, but there still remain in the range of some 37 million to 40 million Americans who are not covered. In the course of the 105th Congress, the extension of coverage to all Americans will be a major topic for consideration.

In my tenure on this subcommittee, I have authored a number of bills including Senate bill 18, which was introduced in the 103d Congress, and with modifications reintroduced in the 104th Congress and will be reintroduced on the first day of the 105th Congress, again with modifications, on my analysis and a projection of ways to cover all Americans within the existing expenditure of approximately $1 trillion.

When we take a look at the issue of Medicare, vitally important to senior citizens, we are grappling with one of the major problems confronting the Nation, and, therefore, the Congress today.

Medicare has been the subject of considerable politicization during the course of the past campaign with the political argument about cuts. Whereas, the effort has been made to reduce the increase in cost, growth in Medicare is now somewhere in excess of 10 percent with the effort to reduce the cost to somewhere in the 7-percent range, which is more than double the rate of inflation.

The budget proposals put forward by both the Republican Congress and the Democratic White House last year were not too far apart, with the projections being somewhere in the range of $148 billion in savings over 6 years by the Republican proposal, and approximately $108 billion in savings by the administration's proposal.

Now that issue will receive a tremendous amount of attention as we move forward because of the difficulties in financing Medicare and the projections of insolvency at some fairly close point in time. That is an issue which is going to have to be addressed.

During the course of the past decade, managed health care has increased tremendously in the United States as a proposed answer to provide management, just as the term states, to emphasize preventative care as an alternative to fee-for-service Medicare.

One issue taken up by the Congress late in the session concerned primary care physicians telling their patients about specialized care. That is an issue which is certainly to be addressed early in the next session. I intend to have a legislative proposal on it myself.

Other issues have arisen about capitation and the motives not to have specialized care. While there is a consensus of the desirability of keeping the Government out of most everything, including health care, it may be necessary for the Federal Government to take a stand on managed health care.

With respect to the enrollment of senior citizens in Medicare HMO's, we note the statistics show very rapid growth. In the last 10 years, participation in Medicare HMO's tripled from approximately 1.6 million participants in 1986 to more than 4 million today. There are projections of an estimated 9.3 million by the year 2002, which would be approximately 25 percent—I wish it was 25 cents—but 25 percent of senior citizens.

The focus of our attention today will be on two recent studies, one of which was completed by Dr. John E. Ware of the New England Medical Center; Dr. Ware has distinguished positions at both Tufts and Harvard. The second study, to be released today, will be presented by Dr. Gail Wilensky, the former head of HCFA, and now Chairman of the Physician Payment Review Commission.

Dr. Ware and Dr. Wilensky, if you would step forward at this time, we will proceed with our first panel. My staff cautions me to talk about the time rules. It says here, because the subcommittee would like to devote as much time as possible to discussing your views on the subject at hand, we would ask that you limit your oral testimony to, this says, 4 minutes. Let us make it 5 minutes. We have a series of lights to help you adhere to this time limitation. Accurately stated?

Mr. HIGGINS. Yes, sir.

Senator SPECTER. Dr. Ware, the floor is yours, sir.

SUMMARY STATEMENT OF DR. JOHN E. WARE

Dr. WARE. Good morning, Chairman Specter. My name is John Ware. I am a senior scientist at the Health Institute at New England Medical Center. I also teach at Tufts University School of Medicine and at the Harvard School of Public Health.

I appreciate very much this opportunity to testify before you and the members of the subcommittee regarding the health care of senior citizens. As you know, several groups are proposing to give Medicare beneficiaries strong incentives to enroll in managed care plans.

Until now, we have had little scientific evidence about how well HMO's maintain the health of seniors who have historically favored traditional fee-for-service insurance over managed care.

The medical outcome study, which is the most comprehensive study of its kind today, provides such evidence. The medical outcome study examined the health outcomes of 2,000 chronically ill patients including 800 seniors covered under Medicare. They were treated in established HMO's and fee-for-service plans in Boston, Chicago, and Los Angeles.

As we reported last month in the journal of the American Medical Association, we measured health outcomes for these seniors over a 4-year period, 1986 through 1990, and we used well-known proven measures of eight health outcomes that matter most to patients including changes in their ability to function in everyday life and their emotional well-being.

Health scores after 4 years were compared with starting scores to determine whether each patient got better, stayed the same, or got worse. We also gathered information on the condition of each patient from the patient's physician, and we monitored patient survival over a 7-year period through 1993.

The results I will summarize today concern summary physical and mental health outcomes in comparisons between HMO's and fee-for-service plans. As we know from earlier studies, younger patients with higher incomes tend to do as well or better in HMO's as in fee-for-service plans.

As shown at the top of the chart, when we analyzed physical health outcomes over a 4-year-period for all patient age groups combined, outcomes on average were the same in the traditional plans as in the managed care plans.

However, as shown on the bottom of the chart, and this chart is also in the handout of the written testimony, seniors under Medicare had worse outcomes in HMO's. Seniors were twice as likely to decline in an HMO than in a fee-for-service plan. In HMO's, 54 percent got worse, 28 percent in a fee-for-service plan. We observed this pattern of results at all three study sites.

Not shown in the chart, for seniors who are also poor the difference in outcomes was even larger. Seniors who were poor, 68 percent declined in HMO's, compared with 27 percent in traditional fee-for-service plans. For mental health outcomes, a higher percentage got better with managed care, but we observed that advantage in only one study site.

We draw four important lessons from this study. First, in monitoring the quality of current HMO care, it is essential and it is also valid to listen to the voice of the people. Their assessments of changes in their functioning and their well-being added significantly to our understanding of which health care plan worked best for them not just in terms of price, but in the quality of their life and the satisfaction with their care.

Second, the science of outcomes assessment has advanced to the point of being sensitive to changes in health. It is well accepted by seniors and it is practical for long-term monitoring.

Third, these results suggest that chronically ill seniors and poor patients were at greater risk of an unfavorable health outcome in an HMO.

Thus, policymakers should not base conclusions about what will work for seniors on average outcomes for the general population in HMO's. I would remind us of the man who drowned walking across a river he had been told was an average of only 3 feet deep.

PREPARED STATEMENT

Finally, all HMO's are not created equal. One HMO did better than the others that we studied in improving the mental health of seniors while controlling health care costs. Therefore, results regarding health outcomes and other quality indicators should be monitored and reported to the public on a plan-by-plan basis.

My written testimony cites 130 publications from the medical outcome study and also lists additional details on the methods and results.

Thank you very much for this opportunity to testify.

Senator SPECTER. Thank you very much, Dr. Ware. Your full testimony will be made a part of the record, in accordance with our standard practice.

[The statement follows:]

PREPARED STATEMENT OF JOHN E. WARE, JR.

Good morning, Mr. Chairman. My name is John Ware. I am a Senior Scientist at The Health Institute, New England Medical Center and I teach at Tufts University School of Medicine and Harvard's School of Public Health. I appreciate this opportunity to testify before you and the members of this subcommittee regarding the health care of senior citizens.

As you know, several groups are proposing policies to give Medicare beneficiaries strong financial incentives to enroll in managed care plans. Until now, however, we had little scientific evidence about how well HMO's maintain the health of the elderly, who have historically favored traditional fee-for-service insurance over managed care.

The Medical Outcomes Study, the most comprehensive study of its kind to date, provides such evidence. The MOS examined the health outcomes of 2,000 chronically ill patients, including 800 seniors covered under Medicare; they were treated in established HMO's and fee-for-service plans in Boston, Chicago, and Los Angeles. As reported in the Journal of the American Medical Association on October 2nd, we measured health outcomes over a four-year period (1986 through 1990), and we used well-known, proven measures of eight health outcomes that matter most to patients, including changes in their ability to perform everyday life activities and in emotional well-being. Health scores after four years were compared with starting scores to determine whether each patient got better, stayed the same, or got worse. We also gathered information on their condition from each patient's physician and we monitored patient survival over a seven-year period (through 1993). The results presented today concern summary physical and mental comparisons between HMO and fee-for-service plans.

As we know from earlier studies, younger patients with higher incomes tend to do as well or better in HMO's as in fee-for-service. As shown in the top of the chart, when we analyzed physical health outcomes for patients of all ages combined, outcomes on average were the same in traditional as in managed care plans. However, as shown at the bottom of the chart, seniors under Medicare had worse outcomes in HMO's. They were twice as likely to decline in HMO's than in fee-for-service plans (54 percent versus 28 percent) in all three study sites. Not shown on the chart for seniors who also were poor, the difference in outcomes was even larger (68 percent declined in HMO's compared to 27 percent in a traditional plan). For mental

health outcomes, a higher percentage got better with managed care but only in one site.

This study offers four important lessons.

First, in monitoring the quality of current HMO care, it is essential, and also valid, to listen to the "voice" of the people. Their assessments of changes in their functioning and well-being added significantly to our understanding of which health care plan worked best for them—not just in terms of price, but also in their quality of life and their satisfaction with their health care.

Second, the science of outcomes assessment has advanced to the point of being sensitive to changes in health, well accepted by patients, and practical for long-term monitoring.

Third, these results suggest that chronically ill seniors and poor patients were at greater risk for unfavorable outcomes in HMO's compared with fee-for-service plans. Thus, policymakers should not base conclusions about what will work for seniors on the basis of average outcomes for the general population in HMO's. I would remind us of the man who drowned walking across a river that he was told was on average only three feet deep.

Finally, all HMO's are not created equal. One HMO did better than others in improving the mental health of seniors while controlling health care costs. Therefore, results regarding health outcomes and other quality indicators should be monitored and reported to the public on a plan-by-plan basis.

MEDICAL OUTCOMES STUDY—4-YEAR PHYSICAL HEALTH OUTCOMES

[In percent]

	Fee for service	HMO
Were the same in analyses of all patients:		
Better	15	15
Worse	27	30
Same	58	55
Favored fee-for-service for seniors on Medicare:		
Better	9	9
Worse	28	54
Same	63	37

Source: "Health Outcomes for Chronically Ill Seniors Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study," presented by John E. Ware, Jr., Ph.D., at the Special Hearing on Safeguarding the Health Care of Senior Citizens, Senate Appropriations Subcommittee on Labor, Health and Human Services and Education, Senate Dirksen Office Building, SD–12, Washington, DC, November 13, 1996 (see also: Ware, Bayliss, Rogers, et al., JAMA 1996; 276:1039–1047).

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NOTE.—Starred publications report studywide results and were reviewed by the MOS Steering Committee; an additional 25 articles are in review.

STATEMENT OF DR. GAIL R. WILENSKY, PH.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION

Senator SPECTER. Dr. Wilensky, we welcome you back here. We recollect your service with HCFA. I was interested to hear your comments a few moments ago, that you like it better now. We may go into that in the questions and answers, but the floor is yours for your opening statement.

Dr. WILENSKY. Thank you, Chairman Specter. I recall my times here as HCFA Administrator. I am pleased to be here today as the Chair of the Physician Payment Review Commission. I would also like to introduce Beth Docteur, who was responsible or at least in a significant way involved in the study that PPRC is releasing about access to care under managed care.

It is a very important time to make this information available because, as you indicated, the growth in managed care has been substantial over the last several years and is projected to continue into the future.

There has been very little information available to date about access to care and satisfaction with care for those elderly seniors who have chosen to be in managed care.

One of the important reasons for doing the study was to form baseline information, and also to see whether or not this type of information could be collected in an ongoing way. It is also important to share with you the actual findings that we have on access to care, and satisfaction as reported by this population.

In the big picture, the information looks very good. In general, very few people who are part of managed care leave to go back to the fee-for-service world. About 3 percent of those who are in managed care choose in their monthly option to disenroll, to go back to fee-for-service. About 5 percent take advantage of the opportunity to choose another managed care plan. To the extent that people are voting with their feet, they are suggesting they prefer to stay in managed care.

The second thing is that there are some clear reasons why they make that preference. Most people in managed care have significantly more benefits. At least 75 percent have prescription drug coverage outside of the hospital, one of the areas not covered by traditional Medicare.

Many, the majority, pay no premium whatsoever beyond that associated with Medicare in terms of the part B monthly premium. We understand why it is that they have chosen to go into Medicare managed care.

In general, the big picture is that most of the people who are in this program feel that they have had good access to care with high satisfaction. But, of course, when we look at some of the very specific kinds of information, there are some areas for concern.

In the first place, we know that there are vulnerable populations in Medicare: some of the oldest old, African-Americans, those with low income and those with fair or poor health.

In general, the more vulnerable groups have reported some problems with access to care in Medicare managed care, particularly the nonelderly disabled, that group of people who are on Medicare by virtue of their very significant disabilities before they reach the age of 65.

One interesting finding is that we found that African-Americans in Medicare managed care did not have higher rates of access problems than others, as they do in the fee-for-service world. Although, in general, the vulnerable populations have reported some problems with access.

The second thing we noticed is that among those who return to fee-for-service they tend to report more problems in terms of accessing physicians or getting delays in appointments, undoubtedly the reason they have chosen to go back to fee-for-service.

The third thing we have noticed is that, in general, there are more access problems reported in the Medicare managed care world than there are in the fee-for-service world, a ratio that indicates about three times more problems. Again, overall, in absolute terms, a small number.

We think that what it was suggesting is that there is a need to make sure that people who are about to choose managed care have a better idea what it is they are choosing; that is, they are getting a lot more benefits. At least to date, there are reports of some kinds of problems for some kinds of people. Alternatively, of course, it may be an issue for the Federal Government to step in.

The second issue in terms of where do we go from here, is that while Medicare managed care plans have been very good about getting information out to the seniors before they choose the plan or at the time they are choosing it, there are some problems reported about getting information after you have already joined, if you have a question, making sure that you know that you have appeal rights, and being responsive to the seniors concerned, making sure that there is information available after people are already in the Medicare managed care plan is very important.

Third, we think that because there has been so much growth in Medicare managed care that we may have seen some plans that are going through growing problems of their own. It is especially important that they be aware of the kinds of access problems that small numbers of their own enrollees are reporting, particularly some of the more vulnerable groups.

If we see the growth in the future that HCFA has projected, which if we continue at 25 percent growth rates and premiums for the Medigap plans as reported last year that we are likely to do, then we think it is especially important to keep monitoring this area of access to care.

PREPARED STATEMENT

You, the Congress, have requested and required that PPRC follow the effects of any changes in the fee schedule on access. There may be a need to consider whether some group, PPRC or HCFA, or someone need also to follow and report to the Congress about access of the elderly in Medicare managed care plans as well.

Thank you. I will be glad to answer any questions you may have.

Senator SPECTER. Thank you very much, Dr. Wilensky.

[The statement follows:]

PREPARED STATEMENT OF DR. GAIL R. WILENSKY

Mr. Chairman, I am pleased to be here today to present findings from the Physician Payment Review Commission's survey of Medicare beneficiaries concerning

their experiences with managed-care plans. We launched this project when we found that there was very little information available on the critical issue of access to care in the managed-care program. This survey, which we are releasing today, provides the most comprehensive and nationally representative profile of access to care as perceived by beneficiaries in Medicare managed care.

The results of this survey in many ways mirror what the Commission has found in monitoring access in Medicare fee for service: access is generally very good for most beneficiaries, but some vulnerable groups, such as the nonelderly disabled and those in fair or poor health, have more problems. The study also uncovered certain areas in which Medicare managed-care plans could improve their efforts to protect consumers and to ensure quality and access.

Managed care is growing rapidly in the Medicare program. The number of participating plans has grown substantially in the past few years and enrollment now totals more than 12 percent of beneficiaries, up from 9 percent at the end of 1994 (Figures 1 and 2). This rapid growth is expected to continue in the future. Although the Congress is clearly interested in expanding the managed-care options available under Medicare, very little is known about how beneficiaries are faring now. Both the Health Care Financing Administration and the Commission are required to monitor the effects of the Medicare fee schedule on beneficiary access, but no similar requirement exists for Medicare managed care. Nevertheless, we could not ignore the growing prominence of managed care in the Medicare program and the need to understand its impact on beneficiaries.

The Commission developed this survey of Medicare beneficiaries because very little data were available to monitor access in Medicare managed care and little work had been done to develop and test measures for evaluating access under managed care. We had two objectives in mind. First, we wanted to develop baseline information on access to care for managed-care enrollees and disenrollees. Second, we wanted to learn what it would take to collect this type of information on a regular basis in the future so that it could be used to inform policy decisions.

My testimony will describe the work that was done and present some of the key findings from this study. I will also briefly mention some of the Commission's conclusions regarding the policy implications of the study and lessons for further work in this area.

FIGURE 1.—*Number of Risk Plans Participating in Medicare, 1990–96*

	Plans
1990	96
1991	93
1992	96
1993	110
1994	154
1995	183
1996 (October)	238

Source: Health Care Financing Review, 1996 Statistical Supplement: Medicare Managed Care Contract Report, October 1996.

Note: All data are for December, except for 1996.

STUDY APPROACH

I know that you, Mr. Chairman, and the other members of the subcommittee have received a copy of our study that describes the methods used in great detail, so let me just touch on a few points before presenting the findings. The survey was developed and fielded by researchers at Mathematica Policy Research, who also analyzed the findings for us. The development of the survey instrument involved considerable work to identify appropriate access measures and to craft new ones where they were needed. Telephone interviews were conducted with more than 3,000 Medicare beneficiaries who were enrolled in a Medicare risk plan for at least two months during the year ending in February 1996. Because this population is composed primarily of continuous enrollees (63 percent) and new enrollees (29 percent), both plan switchers (5 percent) and disenrollees to fee for service (3 percent) were over sampled to obtain adequate representation. Disabled beneficiaries, the oldest-old, and African American beneficiaries were also over sampled so that we could evaluate the experiences of these potentially vulnerable groups. The survey was fielded between May and July of this year, and it achieved a 65 percent response rate, comparable with other recent telephone surveys of this population.

FIGURE 2.—ENROLLMENT IN MEDICARE RISK AND COST PLANS, 1990–96

[Percent]

Year	Risk-contract plans	Cost-contract plans
1990	3.3	2.1
1991	3.8	2.1
1992	4.4	2.2
1993	5.3	2.4
1994	6.6	2.1
1995	8.8	1.9
1996 (October)	10.6	1.7

Source: PPRC analysis of Medicare Managed Care Contract Reports.

Note: All data are for December, except for 1996.

The survey questioned Medicare beneficiaries about a variety of dimensions of access, including: the ability of enrollees to get different types of care, consequences of not receiving care, satisfaction, use of preventive services, receipt of recommended visits for those with chronic conditions, information provided to new enrollees on how to use the plan, and enrollees' awareness of their rights to appeal plan decisions about their care.

The study also examined the extent of disenrollment and reasons for disenrollment as measures of beneficiaries' satisfaction and access.

FINDINGS ON ACCESS TO CARE

Before we go through the results in more detail, let's first step back and look at the bigger picture. The survey respondents provided us with a generally favorable profile of Medicare managed care. Many beneficiaries join managed-care plans to obtain what they perceive to be more comprehensive health care coverage at a lower cost. More than three-quarters of those surveyed obtain prescription drug coverage and a comparable percentage pay no premium in their plan. The great majority of enrollees do not report barriers in accessing care and are satisfied with the care they receive and with their plan. Medicare managed-care enrollees are more likely than their fee-for-service counterparts to obtain preventive services. Moreover, differences in access between groups of beneficiaries who are vulnerable to access problems and others are substantially smaller in managed care than in fee-for-service Medicare.

Along with this good news come some findings of potential concern. While no particular access problems were found to be widespread, certain types of access problems are relatively more common. Vulnerable subpopulations of enrollees have significantly higher rates of access problems than do others. One in four enrollees would not recommend their plan to a family member or friend with a serious or chronic health problem. In addition, many of those who choose to leave their plans, particularly those among the minority who return to fee-for-service Medicare, report that they do so because of problems with their plan's physicians or with access to care. Finally, although the ability to make comparisons with fee-for-service Medicare in this respect is very limited, it appears that beneficiaries in managed-care plans are considerably more likely (up to three times more likely, on average) to report problems with access to care.

Reasons for enrollment and disenrollment.—Medicare beneficiaries have the opportunity to enroll in a managed-care plan at any time during the plan's open enrollment period. Many plans offer continuous open enrollment. In addition, beneficiaries have the option to disenroll from their plans to return to fee-for-service Medicare or to join another managed-care plan at the end of any month.

Our study looked at the reasons why beneficiaries enroll in and disenroll from risk plans. These reasons help us understand what beneficiaries like and dislike about managed care and how the program could better respond to consumers' preferences.

One way that managed-care plans may facilitate access to care is by offering a more expansive benefits package than that of traditional fee-for-service Medicare and by lowering beneficiaries' out-of-pocket costs. Nearly half of all beneficiaries surveyed (enrollees and disenrollees) cited the reduced costs or increased benefits of a risk plan as their primary motivation for joining (Figure 3).

FIGURE 3.—*Beneficiaries' Reasons for Enrolling in Medicare Risk Plans*

	Percentage
Costs/benefits	47
Providers in plan	12
Friend/relative recommendation	10
Other	11
East of physical access	4
Marketing	7
Employer/union offered	9

Source: Mathematica Policy Research survey for Physician Payment Review Commission.

The prevalence of other reasons for joining varied by beneficiaries' enrollment status. For example, a plan's providers were a leading reason for joining a plan, particularly for current enrollees, 12 percent of whom said that this was the key reason they joined (vs. 8 percent of disenrollees). Beneficiaries who disenrolled were much more likely than current enrollees to report that a salesperson influenced their decision to join (11 percent vs. 6 percent).

Although only a small percentage of enrollees leave their plans (about 8 percent), their experiences can provide important insights. Beneficiaries leave their plans for both voluntary and involuntary reasons. Only about a third of those who leave their plans return to fee for service. Of those who do so, nearly 40 percent left because of problems with their plan's physicians or access concerns (Figure 4). More than a quarter left because they moved out of their plan's service area or for other involuntary reasons. Those who switched plans differed from disenrollees who returned to fee for service in their reasons for making the change. Plan switchers were more likely than disenrollees to have left their plan because their doctor left, died, or retired, (10 percent vs. 1 percent) and less likely to have left because of access problems (4 percent vs. 10 percent).

FIGURE 4.—*Beneficiaries' Reasons for Disenrolling from Risk Plans to Medicare Fee for Service*

	Percentage
Access problems/location	14
Involuntary reasons	28
Misunderstood plan rules	4
Financial issues	18
Other	10
Problems with physicians	26

Source: Mathematica Policy Research survey for Physician Payment Review Commission.

The survey also asked current enrollees about their intention to remain with their plan. Only 4 percent of current enrollees reported that they either planned to disenroll from their current risk plan or wanted to disenroll but felt that they could not. The key reason given by those who felt that they could not leave was their concern that they could not afford other health insurance.

Perceived barriers to care or problems with access.—To assess whether beneficiaries perceived barriers to care in their plans, the survey asked whether they had any problems obtaining specific services or making appointments, whether they had experienced delays in obtaining care while awaiting plan approval, and whether they had any other problems obtaining care in their plan. Overall, the levels of access problems were low (Figure 5). Only 8 percent of current risk plan enrollees said that they had trouble making appointments in their plan, and only 5 percent reported experiencing delays in getting care while waiting for plan approval. Six percent of those who were hospitalized felt that they had been discharged too soon, and a similar percentage of beneficiaries had not been referred for specialty care that they felt they needed. More problems were seen in the area of home health services, where 17 percent of those who had used some services said they wanted more than they were able to get. Disenrollees to fee for service, who constitute only a very small percentage of the total population, were about twice as likely as current enrollees to report most types of access problems.

FIGURE 5.—SELECTED ACCESS MEASURES FOR RISK PLAN ENROLLEES AND DISENROLLEES

[In percentage]

	Enrollees	Disenrollees
Had trouble making appointments	8	15
Experienced delays waiting for plan approval	5	10
Not referred for specialty care wanted	6	14
Not admitted to hospital when wanted	1	4
Felt discharged too soon if hospitalized	6	14
Wanted more home health services, if used any	17	36

Source: Mathematica Policy Research survey for Physician Payment Review Commission.

Utilization of preventive services.—Findings on preventive care for managed-care enrollees are encouraging. Two-thirds of enrollees reported receiving a flu shot the previous winter, and the percentage of female beneficiaries who had received a mammogram in the past year was nearly as high at 62 percent (Figure 6). These rates were higher than those for Medicare fee for service, which were 58 percent and 39 percent, respectively. These findings were consistent with expectations regarding the emphasis on preventive care in managed-care plans.

FIGURE 6.—USE OF PREVENTIVE CARE IN MEDICARE IN THE PAST YEAR

[Percentage]

	Fee-for-service	Manage-care enrollees
Had flu shot	58	66
Had mammogram (women)	39	62

Source: Mathematica Policy Research study for Physician Payment Review Commission.

Note: Estimates for fee-for-service beneficiaries were adjusted to account for differences between managed-care enrollees and fee-for-service beneficiaries in age, race, and health status. However, the difference in mammography may reflect differences between the two groups in the age distribution of women within the 65 to 84 age range, since some guidelines do not recommend annual mammograms for women after age 75.

Other indicators of access.—Some of the indicators of potential access that were used in the study highlighted areas in which improvement would be desirable. Two examples are in the area of consumer information. Of new managed-care plan enrollees, almost all—96 percent—reported receiving enough information from their plan at the time they enrolled to make them feel comfortable about using it. Plans appear to do less well in meeting subsequent or additional needs for information, however. Of the 25 percent who had a question or who wanted more information, a fifth had problems obtaining it or tried to get the information without success. Similarly, while most beneficiaries said that they knew they had the right to appeal if their plan refuses to pay for or provide a service, nearly a third were unaware of their appeal rights. This finding raises concerns since such knowledge is an important element of consumer protection in a managed-care environment. The importance of information cuts across both managed care and fee for service. Unfortunately, we have no data by which to estimate fee-for-service beneficiaries' experiences in this area.

Satisfaction.—The findings on enrollee satisfaction are consistent with our findings on access (Figure 7). Nine in ten current enrollees would recommend their plans to friends or family members. That proportion drops to three-quarters who would recommend their plan to someone who was seriously ill or who had a chronic condition. Nearly half of all current enrollees rated the overall quality of care, the ease of seeing a primary care physician of choice, and the choice of specialists as excellent. Only 4 to 7 percent rated their plans as fair or poor on these dimensions. Again, disenrollees were less satisfied, and were considerably less likely to recommend their plan to others.

Access and satisfaction for vulnerable groups.—Certain groups of beneficiaries experience higher rates of access problems than their counterparts (Table 1). Groups who were found to be more vulnerable to experiencing access problems in Medicare managed-care include many of those groups found to be vulnerable in fee for service.

They include: The nonelderly disabled, the oldest old, those with functional impairments, those in fair or poor health, and those with worsening health.

The rates of access problems among vulnerable groups ranged from about a third higher than their counterparts to rates more than twice as high. This translates to a finding, for example, that nearly one out of four beneficiaries who are either disabled or in fair or poor health reported experiencing access problems in their plan.

FIGURE 7.—SELECTED SATISFACTION MEASURES FOR MEDICARE RISK PLAN ENROLLEES AND DISENROLLEES

[Percentage]

	Enrollees	Disenrollees
Rated overall health care covered by plan as excellent	44	25
Rated overall health care covered by plan as fair or poor	4	24
Rated ease of seeing primary care physician of choice as excellent	45	30
Rated choice of specialists available as excellent	45	30
Would recommend plan to family/friends	91	57
Would recommend plan to those with serious/chronic health problem	75	44

Source: Mathematica Policy Research survey for Physician Payment Review Commission.

The groups of enrollees who experienced more access problems and the groups who reported lower satisfaction were not, for the most part, one and the same. African American beneficiaries, for example, reported significantly lower satisfaction than white beneficiaries, but they did not experience a higher rate of access problems. Another interesting finding was that those groups who had more access problems or lower satisfaction were just as likely as others to say they would recommend their plan to someone with a serious or chronic health problem.

Because vulnerable populations may be more likely to have access problems just because they have greater needs for care (and thus more opportunities to encounter problems), the study also looked at the rates of access problems among only those who had either used or wanted to use a particular service. In most cases, greater need for care was responsible for much of the difference in rates of access problems between vulnerable groups and their counterparts. But even after adjusting for differences in the need for care, the nonelderly disabled were twice as likely as beneficiaries in the 65-to-84 age group to report problems obtaining home health care or specialty referrals.

TABLE 1.—SELECTED ACCESS MEASURES FOR BENEFICIARY SUBGROUPS

[Percentage]

	All beneficiaries	Non-elderly disabled	Oldest old	African American	In fair or poor health	In worse health than a year ago	With a history of cancer, heart disease or stroke	With functional impairment
Not referred for specialist care enrollee thought was needed	6.2	9.5	5.8	4.4	8.8	11.4	6.5	4.7
Not admitted to hospital when enrollee thought was needed	1.4	3.4	3.3	2.6	3.8	3.1	1.7	3.7
Felt discharged too soon if hospitalized	6.2	10.0	9.8	8.3	7.0	8.3	7.2	13.2
Did not receive home health care thought needed	1.6	4.1	5.4	2.7	5.6	6.4	2.5	7.6
Experienced delays while waiting for plan approval	4.8	10.8	4.6	2.7	9.3	11.7	6.1	8.2

Source: Mathematica Policy Research survey for Physician Payment Review Commission.

Comparisons with fee-for-service Medicare.—The primary purpose of our study was to assess access in Medicare managed care, but comparisons with fee-for-service Medicare were also sought, where possible, to put the findings in context. To make such comparisons, we used data from the Medicare Current Beneficiary Survey (MCBS), which was designed to measure access and other issues under fee for service. The extent to which we can compare access between Medicare managed care and fee for service is greatly limited by differences in both survey design and the characteristics of beneficiaries in fee for service and those in managed care. Also, the most recent data for fee for service were collected in the fall of 1994, eighteen months prior to our study.

Despite these limitations, a few comparisons of access in Medicare managed care and fee for service could be made. First, the findings suggest that beneficiaries in managed-care plans are more likely to report access problems than are those in fee-for-service Medicare (Table 2). Medicare managed-care enrollees were three times more likely than their fee-for-service counterparts to report some problem with access to care (13 percent vs. 4 percent). Of particular concern is an even larger difference (16 percent vs. 3 percent) between managed care and fee for service in reported access problems among the oldest old, which suggests that managed-care plans may be weaker in providing chronic care than in providing acute care. Differences between our survey and the MCBS complicate the interpretation of these findings, because their effect is to inflate the magnitude of the differences between managed care and fee for service. The observed differences are large enough, however, to rule out the possibility that they are entirely due to differences in how the information was gathered.

TABLE 2.—COMPARISON OF REPORTED ACCESS PROBLEMS BY VULNERABLE SUBPOPULATIONS IN MEDICARE MANAGED CARE AND FEE FOR SERVICE

[Percentage]

	All Beneficiaries	Nonelderly disabled	Oldest old	African American	Low income [1]	Fair or poor health
Percent of fee-for-service beneficiaries who had trouble getting care in past year [2]	4.0	14.1	3.1	8.2	7.8	9.3
Percent of managed-care enrollees who have ever experienced access problems in their plans: [3]						
All enrollees	13.3	24.9	16.1	12.6	15.9	23.6
Those enrolled for one year or less	12.0	21.3	23.1	13.6	16.5	26.1
Likelihood of access problems by vulnerable subgroups relative to their counterparts (ratio): [4]						
Fee-for-service beneficiaries	....	5.2	1.1	2.4	3.9	11.6
Managed-care enrollees:						
All	....	2.0	1.3	0.9	1.3	2.2
Enrolled for one year or less	....	2.1	2.2	1.2	1.9	4.5

[1] Low income is defined as an annual household income of less than $10,000.

[2] For fee-for-service beneficiaries, the access measure shown is the percentage who reported having trouble getting health care they wanted or needed within the past year.

[3] For managed-care enrollees, the access measure shown is the percentage who reported one or more of the following problems since enrolling in the plan. not being referred for specialist care wanted, not being admitted to a hospital when wanted, being discharged from a hospital before feeling ready, not receiving home health care wanted, experiencing delays obtaining care, and experiencing any other problems obtaining care.

[4] The ratio is the proportion of the subgroup with access problems divided by the proportion of the counterpart with access problems. For the ratio of access problems by vulnerable subgroups relative to their counterparts, the counterparts are beneficiaries ages 65 to 84 (for comparison of the nonelderly disabled and the oldest old), whites (for African Americans), those with an annual household income of over $20,000 (for those with low income), and those in excellent health (for those in fair or poor health).

Source. Mathematica Policy Research survey for Physician Payment Review Commission.

Although the overall rate of reported access problems appears higher in Medicare managed care, it is noteworthy that the differences between vulnerable groups and others are larger in fee for service than they are in managed care. The finding is especially encouraging for African Americans, who are over twice as likely as others to report access problems in fee-for-service Medicare, but are less likely than beneficiaries of other races to report access problems in Medicare managed care.

IMPLICATIONS FOR POLICY

The Commission's study has proven valuable in a number of ways. First, its findings on beneficiaries' perceptions and experiences regarding Medicare managed care are reassuring on several dimensions at a time when enrollment is growing rapidly. The study also illustrates the usefulness of survey data for pinpointing problems

The study also illustrates the usefulness of survey data for pinpointing problems that can be addressed by appropriate policy initiatives. There are clearly areas where improvements can and need to be made. In closing, I'd like to highlight some of the study's conclusions that we see as being most important for policy.

First, the Commission's experience with this survey reinforced our view that comprehensive and comparable data on access to care are needed for both the fee-for-service and the managed-care sectors of the Medicare program. The Commission believes that information on access to care needs to be provided to beneficiaries. Such information can help them to understand the differences between fee-for-service and managed-care. Knowing what types of access issues can arise can help beneficiaries to know what questions they should ask of their plans in order to make informed decisions about their health coverage.

One of the particularly important findings from our study is that special attention must be paid to monitoring the experiences of the nonelderly disabled in Medicare managed care. Although they are currently less likely than other beneficiaries to join a Medicare risk plan, the number of disabled beneficiaries enrolling in risk plans is growing. The underlying reasons for these beneficiaries' propensity to have greater access problems in Medicare risk plans needs further examination, particularly as our survey showed that this propensity is not entirely due to their greater need for care. Also, approaches for meeting the special needs of the disabled in the managed-care environment need to be identified and evaluated.

Home health is also an area for future attention. Our study found higher rates of unmet demand for home health services than for other services, with more than 20 percent of those who had either used home health care or wanted to use it saying that they did not get as much care as they wanted or did not get any care. More than two thirds of those beneficiaries reported adverse consequences from not receiving the home health care they believed they needed, including 24 percent who said that their condition worsened as a result. These findings are of policy interest, particularly when considered in the context of findings from other studies that found much shorter average episodes of home health care in managed-care plans than in fee for service. At the same time, this finding must be considered in the context of rapid growth of home health care in fee-for-service Medicare, which may have raised expectations among managed-care enrollees.

In addition to needing information to make their initial health coverage choices, beneficiaries have additional needs for information once they have enrolled. This is an area in which we found that plans could do a better job. As I mentioned, a significant percentage of those enrollees who sought additional information about their plan had problems getting their questions answered. Also, a third of enrollees said they did not know they had the right to appeal a plan's decision not to provide or pay for a service. Our study suggests that plans may need to take additional steps to inform consumers in these areas. Consumer information is likely to be an issue in fee-for-service Medicare as well, although as I mentioned, we do not have data available by which to estimate the extent of the problem.

The Commission's study also suggested some lessons that can be applied to help redesign national surveys so that they provide more comprehensive information on access in a managed-care environment. We plan to share these findings with the Health Care Financing Administration and others interested in ensuring that the Congress and the Administration have the information needed to inform policy decisions on the rapidly growing Medicare managed-care program.

PPRC ACCESS STUDY POPULATION

Senator SPECTER. How many people did your study cover, Dr. Wilensky?

Dr. WILENSKY. The actual sample size was 3,080. They were in the plan, at least 2 months in the year that ended February 1996.

Senator SPECTER. They were in the plan at least 2 months in the year that ended February 1996?

Dr. WILENSKY. Right. There was also oversampling for the vulnerable populations.

Senator SPECTER. What do you mean by that?

Dr. WILENSKY. It is a nationally representative sample so people are chosen to represent the country. But, because the areas of population we are especially concerned about—like the oldest old, African-Americans, and low-income populations—are in smaller num-

bers than the elderly as a whole, if you want to make sure you have enough in your sample to talk about whether they have access problems, you have to oversample and then you reweight them when analyzing the data.

Senator SPECTER. Well, when you say a sample of 3,080 and they were all in the plan for at least 2 months ending February 1996, how long was the person in the longest period of time?

Dr. WILENSKY. The average length of enrollment was 35 months. Everyone in the study was enrolled for at least 2 months. Some people may have been enrolled for as long as the plans have been in existence, which is the late 1980's.

Senator SPECTER. You are saying some people would have been in for as long as 7 years or more, an average of 35 months, and everybody in for at least 2 months?

Dr. WILENSKY. Yes; everyone had to be in at least 2 months to make sure they had some experience.

FFS AND HMO COMPARISONS IN PPRC STUDY

Senator SPECTER. Now, was there a comparison in your plan, as there was in Dr. Ware's plan, people in fee-for-service contrasted to managed care?

Dr. WILENSKY. There was not a good comparison. The only comparison we had was a study called the "Current Beneficiary Survey," which is an ongoing survey started when I was at HCFA, to include a sample of all of the elderly and to follow them over time, so that we would have ongoing measures of use and access and satisfaction.

To the extent that there were comparable or near comparable questions, we have a comparison. We did not have the money to fund a real comparison study that used exactly the same; that would have been better.

Senator SPECTER. Do I take that answer to mean that you do not have a comparison between fee-for-service and managed care?

Dr. WILENSKY. We have some measures. We did not have the same information for fee-for-service and managed care. We do not have that.

Senator SPECTER. When you say you have some comparison, what comparison do you have?

Dr. WILENSKY. Well, there are a number of measures where we look at the number of people who reported having trouble getting care last year in terms of beneficiaries in managed care versus those in managed care.

For example, this is on table II of the testimony. It is primarily in some aggregate numbers of overall difficulties.

Senator SPECTER. Tell me what the aggregate numbers say and what they mean.

Dr. WILENSKY. What they say is that about three times the number of people who are in Medicare managed care have difficulty accessing care as those who are in fee-for-service, the absolute numbers.

Senator SPECTER. Well, that would be comparable to what Dr. Ware says,

Dr. WILENSKY. That is in the aggregate. In the specific, the differences between managed care and fee-for-service are smaller for some vulnerable groups, African-Americans in particular.

Senator SPECTER. Are you saying that it is lower than three times?

Dr. WILENSKY. Yes.

Senator SPECTER. Or, they get better access in managed care than they get in fee-for-service?

Dr. WILENSKY. In that case, I am saying both.

Senator SPECTER. Well, I do not understand that at all.

Dr. WILENSKY. OK.

Senator SPECTER. Let us start with the proposition as to how big your statistical survey is on African-Americans.

Dr. WILENSKY. OK. I misspoke on the issue of do they get absolutely better; it is the differential between African-Americans and others.

Senator SPECTER. What did you misspeak about?

Dr. WILENSKY. In Medicare fee-for-service, 8 percent of African-Americans indicated they had a difficulty receiving care; in managed care, 13 percent reported they had a difficulty. In fee-for-service, African-Americans are more likely than white beneficiaries to report problems accessing care. In managed care, they report access problems at the same rate as others.

Senator SPECTER. Wait a minute, 8 percent had difficulty in getting managed care?

Dr. WILENSKY. Right.

Senator SPECTER. And how many percent had——

Dr. WILENSKY. And 13 percent had——

Senator SPECTER. Wait a minute. How many people are we talking about now? What are the actual numbers? Is your sample big enough to really have the rates?

Dr. WILENSKY. Yes.

Senator SPECTER. How many people are you talking about?

Dr. WILENSKY. The absolute, in terms of the sample size, I do not have that.

Senator SPECTER. Well, I would like to know that.

Dr. WILENSKY. My information in terms of——

Senator SPECTER. While you take a look at that, let me turn to Dr. Ware for just a moment.

Dr. Ware, your study is from 1986 until 1990, and your report was published on October 2 of this year, 1996. What took so long to conclude the study and then write the report?

Dr. WARE. I think that is a very good question. This study was a vanguard study in a number of respects. There were many methodological issues that we addressed for the first time in this study.

Even after the time we ended data collection in 1990, we did not start analyzing the—we had to prepare the data for analysis. The particular summary measures that we developed for purposes of this study had never been developed before.

The journal wanted independent peer review not by a clinical policy journal, but by a methodological journal of those methods. Those were independently peer reviewed and published prior to our using them in a major policy study.

Senator SPECTER. When was that publication made?

Dr. WARE. That publication occurred in 1995. The peer review process itself, which I can attest to, is the most thorough peer review I have ever experienced in 25 years in this field. It was very constructive and very thorough. The responses we were exchanging were much longer than the article itself.

Senator SPECTER. When did the peer review start?

Dr. WARE. The peer review on this particular paper started a little over 1 year before the publication of the actual——

Senator SPECTER. It starts in 1994?

Dr. WARE. Yes.

Senator SPECTER. Well, why the lapse between 1990 and 1995?

Dr. WARE. Well, the methodology that we used to define changes in health status itself was not published until the 1994 and 1995. The good news is that for the next study of this type and, for example, the new seniors health measure that HCFA is adopting these methodological problems have been solved and they don't face the next group that does this type of study.

I would also take this opportunity to point out that we need an entity not a patchwork of grants and foundation support and unsolicited research proposals to various agencies. We need something that is more organized than that to monitor——

Senator SPECTER. What do you suggest?

Dr. WARE. I suggest an agency be given that responsibility. We certainly have some capable ones. But something other than a bunch of independent——

Senator SPECTER. Which one do you suggest?

Dr. WARE. I would want to benefit from their knowledge, since they are much closer to their own staff and their capabilities, but either the Health Care Financing Administration, the Agency for Health Care Policy and Research.

They are also cooperating with the major accrediting organizations such as JCAHO, and the NCQA. In fact, those organizations are helping to define the standards in this field.

Today, there is no reason why we couldn't take outcomes, if anyone in this room knew the 4-year health outcomes of their seniors from 1992 to 1996, and have those results published within 6 months, if someone were funded to do that.

Senator SPECTER. Doctor, I raise the question because there has already been a comment made about your study as to the lapse of time. I would like to have you submit, if you would, to the subcommittee in writing just what the timeframe was when you finished the basic study, the lapse which leads up to the October 2 date so we can have a frame of reference and perhaps can use that as a basis for trying to find some way to get the studies done more rapidly.

Dr. Ware, in your studies, did you come upon any problems about having primary care physicians in managed care inform their patients about the availability, necessity, desirability of specialized services?

Dr. WARE. Yes; I think this is an important consideration in comparing the results of the two studies you have just heard about this morning. The differences that we observed between HMOs and traditional plans, many of the differences occurred after they gained

access to the system. First of all, they were substantially less likely to get inpatient care. Our seniors were 2½ times——

Senator SPECTER. Less likely to get patient care after they enrolled in the plan?

Dr. WARE. Well, during the period we observed them, one of the ways the plans save money is to do as much of the delivery of care outside of any expensive and risky inpatient facility. Honest doctors disagree on how far you can go with that cost-containment strategy without harm to health.

Senator SPECTER. Let me interrupt for just a moment. I have to excuse myself for just a few minutes, and we will come right back to this. We will stand in recess for just a few minutes.

Dr. WARE. Thank you.

[A brief recess was taken.]

Senator SPECTER. We will resume.

Doctor, you were testifying about difficulties that are determined after someone gets into a plan contrasted with before. Would you amplify that, please?

Dr. WARE. Yes; could I finish a point on the agencies. Whichever agency is given this responsibility, we need to insulate that agency from the wrath of the half of the health care community that is not going to like the result of either a quality study or an outcome study.

There are winners and losers almost always. If the agencies are in jeopardy as a result of whether some vested interest group does not like the results, they cannot function.

I do not know the best answer as to which agency in the Federal Government currently has the best capability to do the kind of thing that I recommended. Whoever it is, they need to be insulated from what we call the "shoot the messenger" phenomenon. My other point had to do with——

Senator SPECTER. I don't know how you do that.

Dr. WARE. Well, I think we have had some very good recent examples of what goes wrong if we do not.

Senator SPECTER. We have had a lot of examples. We would be interested in problems you faced specifically on the time delay, and what your recommendations are as to a model. I think that is something which needs to be done, and we can see to it that it gets done.

We can make an allocation or appropriation, if necessary. I would not want to wait until the next appropriation bill. We can move ahead on that. These judgments are very important.

I am very interested in the specifics as to what was found. When you have 8 percent and 13 percent, as Dr. Wilensky is testifying about, I want to know what those numbers mean. We are about to come back to that.

Because these generalizations carry a lot of impact if you have a conclusion that fee-for-service is better than managed care. I want to know the tough statistics and the way you get there. That is what we need to know.

When you talk about—pursuing that line for just a moment before getting back to what happens to people after they once get into the care—2,000 people in your survey, how many of them were in managed care, and how many were in fee-for-service?

Dr. WARE. By design they were, roughly, evenly divided between prepaid plans, prepaid practice HMO's, and the more popular current IPA model HMO and fee-for-service.

Senator SPECTER. What effort was made, or is it relevant, to see what condition they were in at the time they went into the plan? If you have 1,000 people, is that enough to say that if 54 percent are worse on managed care, that that is a big enough sampling that you wouldn't expect it to be worse because of some particularities of the people in the group?

Dr. WARE. One of the most important methodological issues in health care policy evaluation in America today is to better understand how to study self-selected groups that choose a particular style of practice, and it is very clear the public wants that choice.

People tend to gravitate to plans that have the features that are good for them and for their families. That causes the "health stock," so to speak, the risk and the cost to be distributed in an uneven way.

Senator SPECTER. I could not have articulated my question better. Now, what is the answer?

Dr. WARE. The answer is we have to master the methodology of measuring these differences in risk. For example, in our study——

Senator SPECTER. Well, let me ask the question again. If you have 1,000 people, is that enough to overcome the kinds of considerations you have just specified?

Dr. WARE. The 1,000 people help you to have statistical precision so that you can see a difference in the size that you are interested in, but that does not help you—the sample size does not have anything to do with the other problem, which is, how do you conclude what the outcome would have been if they had both treated the same population, which they didn't.

In our study, and this was one of the things that took years in peer review, we used a new risk adjustment methodology that allowed us to make a fair comparison between HMO and fee-for-service even though fee-for-service, on average their patients were 10 years older, they were more likely to have a chronic condition, they were less likely to be poor. We oversampled——

Senator SPECTER. Fee-for-service on the average was 10 years older?

Dr. WARE. That is a common finding, Mr. Chairman.

Senator SPECTER. Well, I would have expected more of them to be worse off than the managed care people if they are 10 years older.

Dr. WARE. That is why we looked at the outcome, we stratified it by age, so we looked at seniors. In fact, we oversampled seniors in both systems of care to make sure we would have enough of them and that we could compare——

Senator SPECTER. Oversampled seniors. Now, these 2,000 people were not all seniors?

Dr. WARE. That is right, but they were all adults.

Senator SPECTER. How many of the 2,000 were seniors?

Dr. WARE. About 40 percent. We oversampled them. Forty percent were 65 and older, approximately 40 percent, that is the 800.

Senator SPECTER. Well, what did you find as to those who were not seniors?

Dr. WARE. Well, those who were not seniors, very good news for those who favor HMO's as a solution to rising costs. They did as well or better; the better was not statistically significant.

It was very clear that the nonseniors, nonpoor in our study did very well in HMO's that our study showed substantially reduced medical care expenditures. We cut hospitalization rates about 30 percent, those plans did. There were no measurable effects on them.

Senator SPECTER. How about the poor nonseniors?

Dr. WARE. The poor? Anyone who is poor and/or senior; and if you are both, it is even worse.

Senator SPECTER. No; I asked you about the poor nonseniors.

Dr. WARE. The poor nonseniors did significantly worse in the HMOs that we studied than equivalent poor patients in a fee-for-service plan in the same category.

Senator SPECTER. How would you account for that?

Dr. WARE. Our study cannot say in a scientific sense what caused these differences. What we can say is that these differences occurred on the watch of these managed care plans and on the watch of these fee-for-service plans. We also documented a number of things that were very different in these two systems of care.

Senator SPECTER. You could draw no conclusions as to why?

Dr. WARE. We can speculate. I would be happy to offer that speculation, and that is this list of things that were very different for those people who got access to one system as opposed to another. These are clues as to what might——

Senator SPECTER. Right now, we are on the poor people, the poor nonseniors.

Dr. WARE. That is right.

Senator SPECTER. They did worse in managed care than in fee-for-service?

Dr. WARE. That is correct.

Senator SPECTER. You call it "speculation." What is your speculation? Sometimes there is not a whole lot of difference between them. When you talk about opinions and judgments, that is a pretty tough line to draw.

Dr. WARE. In science, we have a very high standard for what we can say for a particular study. When I speculate, I am going beyond that. I am not speaking for my colleagues any more, and I do not have the benefit of peer review.

I think a very important lesson is the poor and the elderly in the United States of America are significantly more likely to decline each year in both systems of care. We are not doing as well for the elderly and the poor as we could in either system. We are not doing as well for those who have a psychiatric disorder. This is in all populations.

Senator SPECTER. Let us try to just stay for just 1 minute with the poor nonseniors on your speculation of a reason why the poor nonseniors do worse in managed care than fee-for-service. Can you address that, please?

Dr. WARE. Yes; under what model of treatment an outcome with less health care be better for poor patients with chronic conditions? When you look at the list of all the things they got significantly

less of, the poor with chronic conditions, they were less likely to be hospitalized.

The fee-for-service poor were two and one-half times more likely to see a subspecialist who was trained in their disease in an HMO relative to a fee-for-service plan. They were significantly less likely to see a doctor they have ever talked to before. The difference in continuity of care is very important if you have a chronic disease for which there is no cure and an awful lot of what you need is caring.

Senator SPECTER. Why would they be less likely to see a doctor that they have seen before?

Dr. WARE. I would ask the managed care organizations to explain that. They have a very——

Senator SPECTER. What about fee-for-service? You are on managed care right now?

Dr. WARE. Everything I have just said is true of how the poor experience the managed care plans that we study differently from the fee-for-service plans.

Senator SPECTER. They were two and one-half less likely to see a specialist?

Dr. WARE. That is correct.

Senator SPECTER. Now, is that related to managed care in a calculated way discouraging seeing specialists?

Dr. WARE. Certainly. The reason we do outcome studies is because we need to better understand how far we can go in restricting access to hospital to subspecialists. Clearly, there is much unnecessary hospital care, subspecialty care in America. We are trying to fine tune that.

One of the problems right now, I would suggest, I would speculate that managed care today in America is a little too blunt. When it implements cost-containment strategies to reduce unnecessary utilization, some of that carries over into the populations for whom that service or that specialty that is being withheld might have been beneficial. There are many examples of that in the literature.

For example, when we try to reduce unnecessary prescribing of antibiotics for viral infections, we also reduce significantly the use of antibiotics for bacterial infections for which they are considered quality of care.

The situation today is that we do not have good enough information systems in managed care to make decisions in real time as to who to withhold care from to save money, which is one of the goals, and maintain the quality for everyone. The poor and the elderly clearly are not able to manage that new style of practice as well as the younger, well-off people in better health.

VULNERABLE BENEFICIARIES IN PPRC STUDY

Senator SPECTER. Doctor Wilensky, let us come back to you if you have those figures. Focusing on your testimony on fee-for-service, the figure was 8 percent compared to 13 percent under managed care. My question was, How big is your statistical base on each?

Dr. WILENSKY. Right. Let me give you the specific answer. The 13 percent number there, 480 of the 3,080 people were African-Americans, and that was about close to 60 people.

Senator SPECTER. What is that 13 percent figure again?

Dr. WILENSKY. Oh, excuse me. The 13 percent of the African-Americans reported some problems in receiving care who were part of managed care, that has ever experienced any access problems in their plan.

Senator SPECTER. Eight percent reported problems under fee-for-service?

Dr. WILENSKY. Among the African-Americans, 8 percent of the fee-for-service beneficiaries reported that they had trouble getting care during the year. It was an attempt in these two different surveys to try to compare what we could see in Medicare managed care versus fee-for-service.

You had earlier asked me why we didn't have a control group like that. I would just like to try to put it in perspective. We are an agency with a $4 million budget. We spent $500,000 doing the survey, because there was no other information that we saw was available when trying to measure access to care under Medicare managed care.

While we think that the methodology and the survey technique is sound, the 3,080 sample is a reasonable number and we have reasonable precision, there is no question that it would have been a better study and we would have liked to have had a study that had a sample that used precisely the same questions with a fee-for-service cohort because we could make much stronger statements.

We thought this was important baseline information, and important as a way to proceed in the future. We hope this will drive the interest in appropriations for someone to continue monitoring this.

NEED FOR AN AGENCY TO MONITOR ACCESS IN MEDICARE HMO'S

Senator SPECTER. Dr. Ware, what do you think of Dr. Wilensky's suggestion that we try to attach some agency with a more comprehensive study of these precise issues?

Dr. WILENSKY. I agree with that. I believe that it needs to occur on an ongoing basis. I believe, although I do not know for sure, that part of what we are seeing is the influx of individuals into managed care organizations, some of whom have more experience than others in dealing with seniors or with sick people.

It is not surprising that some of the seniors, particularly those with certain kinds of health problems may report difficulties because of this large group. I think if we expect it to continue as we do, then it is especially important that we have yearly or biyearly estimates of what is going on with access.

RESTRICTIONS ON SPECIALTY CARE REFERRALS

Senator SPECTER. Dr. Wilensky, in your study of the managed care operations, did you find a problem with respect to primary care physicians being restricted from advising patients of the need for specialty care?

Dr. WILENSKY. Well, what we asked from the patients' points of view whether they had trouble not being referred to specialty care they wanted. We don't know whether the primary care physicians were deliberately intervening or had an incentive.

We found that 6 percent said they were not referred to specialty care that they wanted. Among those who left to go back to fee-for-service, the number was higher.

It is important, again trying to look at our numbers, that while the differences should not be ignored, overall the kinds of percentages we heard being reported of people who had difficulties getting something were in the neighborhood of 5, 6, or 8 percent. That means obviously that somewhere in the 92 to 94 percent of the seniors were satisfied on measures like making appointments, not experiencing——

Senator SPECTER. Can we focus for just 1 minute on being referred to specialists?

Dr. WILENSKY. OK.

Senator SPECTER. You say there was a 5 to 6 percent?

Dr. WILENSKY. Six percent said they were not referred for specialty care that they wished.

Senator SPECTER. Well, what is your judgment as to the balance of the 94 percent that did not need specialty care——

Dr. WILENSKY. Six percent——

Senator SPECTER. Let me finish, please. Six percent felt they needed specialty care, 94 percent did not. Is there any significant number in your judgment among the 94 percent who may have needed specialty referrals but did not know it?

Dr. WILENSKY. Well, 51 percent of all the survey respondents actually were referred to a specialist at least once. What we do not know is, of the percent who were not referred, whether or not there were some who should have been referred, but did not know that that was the case, so they did not have the perceived access problem.

Senator SPECTER. Of the 94 percent, 51 percent were referred. That means that 43 percent were not referred?

Dr. WILENSKY. Well, it means that they did not have a problem, and they did not have a referral. They did not perceive they had a problem and they did not have a referral.

Senator SPECTER. When you testified about the people who were not happy not being referred, did you have any specific knowledge about the arrangements for managed care companies which limited the primary care physician from making a referrals to a specialist?

Dr. WILENSKY. No; they, of course, used different strategies, had different arrangements, depending on whether they are a staff or group model or whether they are a more loosely-affiliated network model. They would typically have different arrangements between the primary care and specialty physicians, but we did not have that.

FINDINGS ON GAG RULE

Senator SPECTER. Do you think there is any substantive concern about the so-called gag rule on managed care operations limiting primary care physicians from referrals to specialists?

Dr. WILENSKY. To use John Ware's phrase, this is going to a speculative role. I have tried to inquire in meeting with various managed care groups whether they engage in such activities, because I think it is a very bad activity to engage in.

It is my impression speaking to them, but not attempting to verify whether it is the case, that most of the larger managed care companies claim they do not engage in such practices and they also believe this is not appropriate.

In one case I recall a very specific decision, that apparently they have done so in the past, and are not doing so. I think that people need information. They need information from their physicians, they need information about whether enrollees in the plan are satisfied, and how often they disenroll, if they are to make good choices.

I think it is a mistake for plans to inhibit information, and that is something that we ought to ascertain how often it goes on. In the areas in which the Government might intervene——

Senator SPECTER. What you are saying is you really do not know how often it goes on?

Dr. WILENSKY. We do not. I do not believe that there is any information.

Senator SPECTER. You talk about speculation, without speculation, we would hardly legislate anything. Seriously, you listen to the statements on the floor of the U.S. Senate and the citations which are made as to facts, to call them a theory would be to compliment them highly. If you want to compare that with what you can put in the courtroom, it would vaporize.

You are an expert in the field, and Dr. Ware is an expert in the field. It is hard to get a little testimony here from time to time without moving over into your speculation.

Your speculation is probably worth a lot more than the best judgment of a member on trying to figure out what is going on here, and that is why I ask you for a sense of it. The central part of your testimony, as I hear it is, you really just do not know how big of a problem the so-called gag rule is.

Dr. WILENSKY. I do not believe there is information that that attempts to ascertain these percentage of plans, that do not allow——

Senator SPECTER. Well, do you know of any plans which prohibit or inhibit or in any way limit the primary care physician from telling a patient about a specialist?

Dr. WILENSKY. I have heard physicians claim that they have been interfered with as physicians. I have not seen any listing of plans that assign that as a policy that they support.

Senator SPECTER. Would it be too big a burden for you to focus on that particular issue and give the subcommittee a supplemental answer?

Dr. WILENSKY. No; I think that we could. If we do not have it, we could even make calls to the various plans.

Senator SPECTER. I would greatly appreciate it. That is a fact that we would like to know one way or another.

Dr. WILENSKY. I would also like to know it.

Senator SPECTER. Dr. Ware, your hand is up. Before you volunteer, would you deal with the last question, that is: Do you have a judgment or speculation about the extent to which managed care companies limit primary care physicians from informing patients about the need for special treatment?

Dr. WARE. We actually have specific evidence on that. It is again important to keep in mind the years of our study. Many experts speculate that these pressures are much greater today.

Senator SPECTER. We have kept in mind the years of your study. What is the answer to the question?

Dr. WARE. The answer is that the physicians in the HMO's that we studied we surveyed them at the beginning of our study. They were much more dissatisfied with their autonomy with respect to practice, communication, a number of different aspects of the practice of medicine in HMO's relative to——

Senator SPECTER. Physicians were discouraged with their autonomy?

Dr. WARE. That is right.

Senator SPECTER. Now, does that mean that they were prevented by the managed care companies or inhibited or suggested that they not inform patients about the desirability of a specialist referral?

Dr. WARE. Well, we know that specialty referrals were significantly less likely to occur in the HMO's we studied. We also reported in the Journal of the American Medical Association in 1994 that patients had significantly more access problems to specialists using the IOM criteria of availability in the HMO's that we studied.

An important point to make at this point is that we are talking about HMO's as if they are all created equal, and there is a saying that if you have seen one HMO, you have seen one HMO. Most doctors in this country practice in both plans. Some of the best doctors in the country are in HMO's.

In our study, the HMO's were significantly different. That is why we think that the plan-specific results on quality should be reported to the public, so they can look at the advantages and disadvantages of each, but they are not all created equal in what we are talking about. Some of them do very well in containing costs and maintaining health. In our study——

Senator SPECTER. Let us stay focused for just 1 minute, if we could, about inhibiting referrals to specialists. If we legislate and say that an HMO cannot have a gag rule, we are not going to affect the ones who do not do it. What I am trying to ascertain is whether there are some who do it.

Now, you have said that there are fewer referrals to specialists with people in HMO's. You can draw an inference from that that something is going on there. Do you know of any specific factual basis that some managed care companies have a specific prohibition directed against a primary care physician from referring a patient to a specialist?

Dr. WARE. All I can say is that our patients reported less access to specialists. We were not in the room when the doctors and patients talked to each other. In general, there is less communication——

Senator SPECTER. Did you examine any documents which established a contractual arrangement between the HMO's and the physicians?

Dr. WARE. No; we did not.

Senator SPECTER. Well, would it be too burdensome for you to respond, as Dr. Wilensky has agreed to, to take a look at that and

see if you can report to the subcommittee some hard evidence one way or another?

Dr. WARE. OK. Could I also offer another opinion? With all due respect, I think the whole notion of micromanaging managed care in terms of what they can do and what they cannot do is a self-defeating approach when you think of the hundreds and thousands of things that occur or do not occur in the practice of medicine.

It is a profession. We should tell them what we are going to hold them accountable for. We should give them a budget, and then we should let them do their thing.

To try to pass laws as to "You can do this, you cannot do that, this is the minimum length of stay for this procedure," that is not going to work. There are too many things in that balloon——

48-HOUR RULE FOR POSTDELIVERY CARE

Senator SPECTER. Do you think it was a bad law to say you had to allow a mother to be in the hospital for at least 48 hours?

Dr. WARE. I think it was a good political thing to do in the short-run, because obviously it was a very salient issue in the eyes of the American public, but to solve the thousands of debates in health care that way is not going to work. We really need to tell doctors what we are going to hold them accountable for, give them a budget, hold them accountable, and let them be professionals. That is what I would suggest.

Senator SPECTER. How about that one item, at least 48 hours after delivery?

Dr. WILENSKY. I thought that was a bad law.

Senator SPECTER. I am asking Dr. Ware.

Dr. WARE. I am an empiricist. I would want to do an outcome study. I would want to look at mothers, if we are talking about so-called drive-thru pregnancies. I was surprised to hear about outpatient mastectomies, but I am open-minded about this.

Senator SPECTER. Well, that was next, but let us finish up on——

Dr. WARE. Well, I am open-minded.

Senator SPECTER. You do not have a judgment as to whether it was a wise rule to have 48 hours for a woman to be in the hospital after delivery?

Dr. WARE. I do not think it would be wise to take anyone's opinion on that. These are too important to not look at the economics, to look at what we are doing to people's lives, and what we are doing clinically to these patients. Without knowing all three of those, I would not place a lot on consensus on expert testimony. We have made a lot of mistakes doing that.

We need good data on all of these issues, and we need an information system that is not going to tell us the answer 6 years later. We need one that is going to tell us in real time, before there is a body count or some other bad outcome.

Senator SPECTER. My colleague, Senator Simms of Idaho, used to say when the Congress was in recess the country was safe. By your standard and level of proof, the country would be safe even when the Congress was in session; we would not pass anything. If you were in the Congress and the vote came up, a minimum of 48 hours, would you vote yes, no, or you would abstain?

Dr. WARE. I would probably represent the voters that I would answer to. Hopefully, I would know their opinion on that issue. I think ultimately we cannot resolve all of those issues that way. To micromanage care in that way is going to be ineffective.

Senator SPECTER. You think Congress ought to stay out of any interference with managed care?

Dr. WARE. No; I think Congress, if we are going to restrict the choice of our public regarding health care, as others have said or I hope will say, we better inform that choice.

We should not allow and we do not allow the drug companies and the device manufacturers to say anything they want about their products. We have a problem right now with our health care plans. Both traditional and managed care can pretty much say anything they want.

Senator SPECTER. You think Congress should legislate on the kind of information the managed care companies have to put out?

Dr. WARE. Just like we do in drugs and devices. I think we need standards of what you have to know about yourself to say you have the best access.

Senator SPECTER. Of what the managed care companies should say, do you think Congress ought to get into it to that extent?

Dr. WARE. Someone has to. The public's interest is at stake. That is where I think the Government could play a major role, but not in micromanaging by defining what processes will be allowed or not allowed. I just think there are too many of them.

Senator SPECTER. You mentioned mastectomies. My wife had complained about that. Just in the past few days, there has been a spate of publicity about turning women out with mastectomies, not lumpectomies but mastectomies. Do you have an opinion on that medical practice?

Dr. WARE. I was surprised, but I am not medically trained. I am open-minded about it. Clearly, we ought to do something about the health care budget, and those decisions need to be informed.

Some of the best managed care organizations in this country already have information systems that can answer the kind of question that you are asking for that particular procedure.

I would be open-minded, given what we have to do to this budget in order to have everyone be in the system and everyone getting, at least, some standard of health care. We need some way of reducing the growing health care costs, which means we have to consider the kinds of things that you are raising.

Senator SPECTER. Dr. Wilensky, you were about to speak up a few moments ago on an opinion as to whether the Congress was right or wrong in requiring that women have at least 48 hours in the hospital after delivery?

Dr. WILENSKY. Correct.

Senator SPECTER. What is your opinion?

Dr. WILENSKY. My opinion it was not a good area for the Congress to get involved in. Both because of the micromanagement issue, that is: of requiring through Federal law that health care health plans pay for a certain number of days; and because, at least in the conversations I had with a number of clinicians in this specific instance, there was considerable debate about whether there was something magic about 48 hours.

I think the specifics were questionable. I was more concerned about the precedent that I thought it raised. I think there will be pressures to put in law certain staffing requirements, so many nurses per beds or per hundred thousand, and other attempts to basically have care as it was in the 1980's or some other period placed into law. That is not a good direction for the Congress to go. But, they did not ask me.

Senator SPECTER. Well, thank you very much, Dr. Wilensky and Dr. Ware. It has been very enlightening. We would appreciate the responses which we have requested.

Dr. WILENSKY. Yes.

Senator SPECTER. We will study your reports.

Dr. WILENSKY. We will get back to your staff in your offices as to how quickly we can review the information, depending on how much new or original work we have to do to get the information, but we will get back shortly as to how much additional time we will need.

Senator SPECTER. Well, we very much appreciate that. Thank you.

Dr. WILENSKY. Thank you.

Senator SPECTER. We will include further written responses in the record at this point.

[The information follows:]

QUESTIONS SUBMITTED BY SENATOR SPECTER

PREVENTIVE SERVICES

Question. Dr. Wilensky, under the traditional Medicare program, what preventive services are covered? What services are covered under Medicare managed care?

Answer. Under the traditional program, Medicare covers the following preventive services:

—Screening mammography once every two years for persons over age 65. They are covered more often for the nonelderly disabled.

—Screening Pap smear once every three years, except for women at high risk of developing cervical cancer.

—Vaccines for influenza, pneumococcal pneumonia and hepatitis B (for those at risk of contracting hepatitis B).

Under the managed-care program, plans are required to provide the full Medicare benefit package. In addition, most plans (98 percent) cover routine physicals. Other preventive services and the frequency with which they are provided by plans include immunizations (88 percent), hearing exams (75 percent), foot care (38 percent), dental care (38 percent), and health education (24 percent).

MARKETING AND CONSUMER INFORMATION

Question. Dr. Wilensky, is there evidence that beneficiaries unknowingly enroll in Medicare HMO's as a result of aggressive sales tactics? If so, what can be done to ensure that beneficiaries base their decisions to enroll on HMO services and quality, and not just on aggressive sales promotions? Do you think beneficiaries should have information to compare HMO options with traditional Medicare fee-for-service?

Answer. Data on retroactive disenrollment and disenrollment within the first 90 days suggest that misinformed or inappropriate enrollments are occurring in some plans and markets. Rapid disenrollment often occurs when beneficiaries do not fully understand either that they are enrolling in an HMO or what it means to do so. In cases where enrollment results from an HMO's misrepresentation or a misunderstanding, beneficiaries can be permitted to retroactively disenroll.

The use of sales agents, who are often paid on commission, to enroll beneficiaries is a source of concern. Sales representatives are allowed to visit with beneficiaries one-on-one, provided that the beneficiary has authorized the meeting in advance. Such arrangements are highly vulnerable to abuse, as it is virtually impossible to monitor this type of activity.

We have evidence that beneficiaries who rely on sales information are more likely to disenroll from their plans than are those who enroll for other reasons. The Physician Payment Review Commission (PPRC) access study showed that 16 percent of beneficiaries who disenrolled from their HMO said that one of the reasons why they joined was information or advice provided by a salesperson. By contrast, only 8 percent of those who had not disenrolled said that a salesperson influenced their enrollment decision.

Current regulations prohibit discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation and giving of gifts or payments to prospective enrollees. These protections should be retained in any restructuring of the Medicare program.

PPRC is also concerned about the potential for problems associated with the requirement that beneficiaries enroll in an HMO through the plan itself. Beneficiaries who attend an enrollment seminar hosted by the HMO may be encouraged to enroll on the spot, even though this could be their first contact with the plan. The Commission has recommended that the Secretary of Health and Human Services provide an enrollment application in the information it gives to beneficiaries to reduce beneficiary reliance on direct contact with a plan during the enrollment process.

In addition to addressing sales and marketing issues, providing beneficiaries with better information is a promising approach to facilitate appropriate enrollment decisions. To make informed choices, beneficiaries should be given comparable information on the benefits and costs of all of their Medicare plan options, including fee-for-service ones. This type of information is currently available only in a minority of areas, although the Health Care Financing Administration is taking steps to increase the information available in other areas.

COMBATING HMO ABUSES

Question. Dr. Wilensky, in what ways will the Health Care Financing Administration (HCFA) take a tougher stand to protect Medicare beneficiaries from poor quality HMO's, or is it sufficient to keep the future focus on providing seniors information to help them choose an HMO?

Answer. Information can play an important role in consumer protection in several ways. First, providing information on Medicare HMO's can help beneficiaries make informed decisions about their health care options. Information on access to care and quality of care in various plans could be useful for this purpose. Information on the Medicare managed-care program in general, like that from our access survey, could also be helpful to beneficiaries in that it can help them understand the strengths and weaknesses of HMO's relative to fee for service. We also think that it is important to ensure that HMO's provide beneficiaries with the information they need to use their HMO once they have joined.

PPRC supports the work that HCFA is doing to enhance its efforts to protect beneficiaries from poor quality HMO's. In addition to providing information to beneficiaries on Medicare HMO's, HCFA has other plans that will improve its ability to ensure quality and access. For example, HCFA plans to increase the frequency of the site visits that it makes as part of its process for certifying that HMO's meet federal requirements for Medicare participation. HCFA has also announced its plans to collect information on the quality of care plans provide, using the so-called HEDIS measures that are now very widely used by private-sector purchasers. HCFA is also working with the Agency for Health Care Policy and Research to develop a consumer satisfaction survey that will permit plan-specific assessments of beneficiaries' experiences with their HMO's.

HOME HEALTH CARE

Question. Dr. Wilensky, do you think that the findings of your survey about beneficiary dissatisfaction with access to home health care signal to those with chronic conditions that HMO's may be less appropriate for their health needs than traditional fee-for-service Medicare?

Answer. Not necessarily. Our study found that 17 percent of Medicare managed-care enrollees who had used home health care wanted to use more services than they received through their HMO. Less than 1 percent said that they didn't get any home health care services when they thought they needed them. We don't have comparable data on the percentage of beneficiaries in fee-for-service Medicare who had problems getting home health care. So we can't say, on the basis of this finding, that access to home health services is more of a problem in Medicare HMO's than in fee for service. We can say, however, that this finding does warrant further study, and consideration in the context of findings from other studies.

LEGISLATION REQUIRING MONITORING

Question. Dr. Wilensky, should Congress enact legislation requiring the Health Care Financing Administration and your Commission to monitor the effects of Medicare managed care plans on beneficiary access?

Answer. Monitoring enables us to advise the Congress on how access to care is affected by various program and policy changes, but there is currently very little information available by which to monitor access for beneficiaries in Medicare HMO's. Our survey demonstrated that collecting this type of information on a regular basis is feasible, and that survey information can be used to determine which groups within the beneficiary population experience problems and what types of problems they experience. We plan to share the lessons that we learned from our survey with HCFA, because we believe that this information will be helpful to them as they assess whether and how to modify the Medicare Current Beneficiary Survey to account for Medicare managed-care enrollment growth.

As more and more beneficiaries enroll in Medicare HMO's and as Congress considers restructuring Medicare to provide more managed-care opportunities, it becomes increasingly important to obtain, on a regular basis, information on how enrollees fare. Under the Omnibus Budget Reconciliation Act of 1989, the Congress directed the Department of Health and Human Services to monitor Medicare beneficiaries' access to care and use of services, and for PPRC to both comment on the Secretary's annual report and offer analysis and recommendations to the Congress in these areas. By adding a requirement to monitor access for beneficiaries in Medicare managed care, the Congress could ensure that analysis and recommendations would be available to inform congressional decisions in a timely manner.

ACCESS TO SERVICES

Question. Dr. Wilensky, what did your survey find with regard to Medicare HMO's and access and use of preventive services? How does this compare with Medicare fee-for-service?

Answer. Our survey's findings were consistent with expectations about the focus on preventive care in HMO's. For example, nearly half of those surveyed said that their plan sent them information encouraging them to get preventive care, and one-third said that their plan doctor encouraged them to do so. We also looked at whether Medicare managed-care enrollees had received six different types of preventive services in the past year: mammogram, flu shot, hearing test, glaucoma test, cholesterol test, and colorectal cancer screening. The results ranged from a low of 22 percent who had received a hearing test to a high of 71 percent who had received a cholesterol test.

As far as comparisons with fee-for-service Medicare, we had comparable information for only two services, flu shots and mammograms. We found that Medicare managed-care enrollees were significantly more likely to have received these services in the past year. 62 percent of female Medicare HMO enrollees received a mammogram as compared with only 39 percent of those in fee for service. And 66 percent of those in Medicare HMO's had a flu shot for the previous winter, as opposed to 58 percent of those in fee for service.

Question. Dr. Wilensky, what access to care problems did your survey uncover and for whom?

Answer. Our study found more problems in home health care than in other areas we looked at, such as specialty care referrals and hospitalizations. We know that 17 percent of beneficiaries who used home health care didn't get as much as they believed they needed, but we were not able to determine whether or not plans were withholding medically necessary care. We also know that use of home health care in fee-for-service Medicare has grown exponentially in recent years, and we think one possible explanation for the rate of problems we found is that beneficiaries' expectations were raised by increased use of this care in fee for service. This is an area that deserves additional study to explore why beneficiaries are having problems and what it means for the quality of care.

We also found that, as is true in fee-for-service Medicare, certain vulnerable populations have higher rates of access problems than others. The oldest-old, the nonelderly disabled, those with functional impairments, those in fair or poor health, and those with worsening health all experienced higher rates of access problems than others. The higher rates of problems among vulnerable groups at least partially reflects their greater need for care and increased opportunity to experience problems. But even after controlling for the need for care, the nonelderly disabled were still twice as likely as beneficiaries aged 65–85 to encounter problems obtaining home health care and specialty referrals. Finding ways to improve health care delivery for

vulnerable populations is an important goal for both fee-for-service and managed-care systems.

Question. Dr. Wilensky, are beneficiaries in Medicare managed care plans more, or less, likely to report problems with access to care? What percentage of respondents to your survey reported access to care problems?

Answer. Our study was designed to provide baseline information on access in Medicare managed care, and we did not have a fee-for-service group in our survey sample. We were able to make some limited comparisons between the findings of our survey and findings from the Medicare Current Beneficiary Survey, an annual survey of Medicare beneficiaries sponsored by the Health Care Financing Administration.

In general, we found that beneficiaries in Medicare HMO's appear to have more access problems than beneficiaries in fee for service. About 12 percent of Medicare managed-care enrollees said that, in the past year, they had experienced at least one of six different access problems that we asked them about, such as delays obtaining care while waiting for plan approval. By contrast, the Medicare Current Beneficiary Survey asks a single, global question about whether the beneficiary has had any trouble getting care within the past year; 4 percent of beneficiaries in fee-for-service reported that they had. Because of differences in how access problems were assessed in the two surveys, we believe that the difference we see between fee for service and HMO's is overstated, but we think that it is too large a difference to be entirely explained by the differences in methodology.

Another finding with respect to comparisons between managed care and fee for service was that the differences between vulnerable beneficiaries and others was generally smaller in managed care. For example, disabled beneficiaries in fee for service were 5 times as likely to have access problems as nondisabled beneficiaries in fee for service. In managed care, disabled beneficiaries were twice as likely as the nondisabled to have problems. This finding was particularly interesting for African Americans, who were twice as likely as white beneficiaries to have access problems in fee for service, but were slightly less likely than whites to have any problems in managed care.

REASONS FOR ENROLLING IN HMO'S

Question. Dr. Wilensky, what was the most common reason beneficiaries reported enrolling in a Medicare managed care plan?

Answer. Half of those beneficiaries surveyed—including both enrollees and disenrollees—told us that their primary reason for joining their plan was that it offered better benefits or lower costs. More than 80 percent of enrollees had prescription drug coverage, for example, which is not provided in fee-for-service Medicare. Also, about three-quarters paid no premium in their plan. Other important reasons for joining were the plan's providers and recommendations from friends or relatives.

AREAS FOR IMPROVEMENT

Question. Dr. Wilensky, what areas of Medicare managed care did your survey find need improvements?

Answer. We found that plans could do better in providing information to their enrollees. While nearly all new enrollees said that they obtained enough information when they joined to make them feel comfortable using their plan, one in five who later wanted more information said that they had trouble getting it. Also, a third of all enrollees said that they did not know they had the right to appeal their plans' decisions about their health care. Information is an important consumer protection, and health plans should make it a priority to ensure that Medicare beneficiaries have the information they need.

LETTER FROM GAIL R. WILENSKY

PHYSICIAN PAYMENT REVIEW COMMISSION,
Washington, DC, December 20, 1996.

Hon. ARLEN SPECTER,
Chairman, Subcommittee on Labor, Health and Human Services and Education, Committee on Appropriations, U.S. Senate, Washington, DC.

DEAR SENATOR SPECTER: At the hearing on safeguarding the health care of senior citizens held by the Appropriations Subcommittee on Labor, Health and Human Services, and Education on November 13, 1996, you asked if the Commission had any evidence on the use of "gag" clauses by managed care organizations in their con-

tracts with physicians. This letter contains information gathered by Commission staff in a review of that issue.

The types of contract provisions that have raised concern are those that may restrict physicians in several ways. They may prevent physicians from fully informing patients about treatment options or about which options are covered by the plan. They may also prohibit referrals to providers for services that are not covered. In addition, contract clauses may prevent physicians from criticizing the plan, disclosing financial incentives, or discussing how decisions to authorize or deny care are made.

Two different types of clauses in particular have come under scrutiny in recent years. Anti-disparagement clauses are designed to prevent disclosure of propriety information and negative publicity about the plan. Provider deselection or termination without cause clauses permit either party to terminate the relationship without cause. Depending on their interpretation, both of these could be considered as "gag" clauses if they compromise communication between patients and physicians, although such provisions do not specifically address issues of medical care.

There are no hard data on the extent to which physicians contracting with managed-care plans are subject to constraints affecting discussions with patients. This is primarily due to the confidential nature of these contracts. In addition, there are differences of opinion about their merits. The industry considers inclusion of anti-disparagement and confidentiality clauses to be a sound business practice. On the other hand, the American Medical Association considers such clauses to have a "chilling" effect on relationships between physicians and patients. Consumer organizations also argue that such conditions, whether explicit or implicit, stifle physician communication with patients.

A number of states and the federal government have already moved to restrict "gag" clauses. Since 1995, 17 states have enacted laws banning these clauses, and a dozen more are considering banning them. The Health Care Financing Administration also recently clarified that contract clauses limiting what physicians may tell Medicare beneficiaries about their treatment options are a violation of federal law.

The industry is also moving to address provider and consumer concerns. Some plans, such as Humana, have announced that they will no longer include such provisions in provider contracts. Moreover, on December 17, the American Association of Health Plans issued guidelines asking plans to inform patients about: how their doctors are paid, including incentive arrangements, how their plan reviews and decides which services will be covered, how their plan determines medical necessity, and how the plan determines whether a proposed treatment is experimental.

The guidelines are voluntary but the association expects all 1,000 of its member plans to put policies into effect by the end of next year.

The PPRC staff will continue to follow developments in this area. If you or your staff have any additional questions, please feel free to contact me or the Commission's Executive Director, Lauren LeRoy.

Sincerely,

GAIL R. WILENSKY, PH.D.
Chair.

LETTER FROM JOHN E. WARE

NEW ENGLAND MEDICAL CENTER,
Boston, MA, January 16, 1997.

ARLEN SPECTER,
Chairman, Subcommittee on Labor, Health and Human Services and Education, and Related Agencies, U.S. Senate, Washington, DC.

DEAR SENATOR SPECTER: I am writing to submit the two items of additional information you requested during the recent Senate hearing: (1) documentation of the chronology of Medical Outcomes Study (MOS) publications leading to publication of differences in health outcomes for Medicare patients treated in managed care (HMO) and traditional fee-for-service (FFS) plans in the October 2, 1996 issue of the Journal of American Medical Association, and (2) findings from the MOS relevant to current concerns about so-called "gag" rules in managed care plans.

In response to your first request, the attached chronology documents when each step occurred in the presentation and publication of MOS methods and results regarding outcomes in managed care, working backward from the most recent publication in JAMA (October 2, 1996).

In response to your second request, we report that differences in the doctor-patient relationship observed between plans in the MOS favored traditional FFS plans

over managed care plans. Included were significant differences (favoring FFS) in the amount of information-giving to patients, as documented in peer-reviewed MOS publications (Rubin et al JAMA, 1993, 270(7), 835–840 and Safran et al, 1994, 271(20), 1579–1586). Of direct relevance to current concerns about "gag orders", chronically-ill patients in HMO's were more likely (than their FFS counterparts) to complain about doctors withholding information (e.g., keeping them "in the dark about care").

I hope you find this information satisfactory and useful. Thank you for the opportunity to submit testimony regarding these very important issues.

Sincerely,

JOHN E. WARE, JR., PH.D.,
Senior Scientist, Principal Investigator, Medical Outcomes Study.

CHRONOLOGY LIST

October, 1996—Manuscript published by JAMA.

August, 1996—Manuscript accepted for publication in JAMA.

July, 1996—Revised manuscript re-submitted to JAMA.

June, 1996—First peer review of manuscript completed by JAMA reviewers with requests for revisions.

November, 1995—Preliminary outcomes for physical summary measure for the average hypertension and diabetes patient reported in JAMA (1995, 274, 1346–1474).

April, 1995—Documentation of MOS summary outcome measures and proof of scientific validity published in Medical Care (1995, 33(4), AS264–279).

December, 1994—Detailed user's manual documenting MOS summary outcome measures along with normative data and interpretation guidelines published (1994, Boston: The Health Institute).

June, 1994—Preliminary MOS results regarding differences in outcomes across plans for poor patients presented at the Annual Meeting of the Association for Health Services Research.

April, 1994—MOS methods for summarizing health outcomes presented at conference sponsored by the Agency for Health Care Policy and Research (AHCPR).

December, 1993—Methodology for scoring physical and mental health outcomes presented at AHCPR-sponsored conference and submitted for peer review and for publication in Medical Care.

June, 1993—Completion of first peer review by JAMA requesting documentation and peer review of methods in a health services research (methods) journal prior to publication in JAMA.

March, 1993—First submission of MOS manuscript using newly-developed summary physical and mental health outcome methodology to JAMA. (2-year data only, no healthcare plan comparisons)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF BRUCE FRIED, DIRECTOR, OFFICE OF MANAGED CARE

ACCOMPANIED BY CLIFTON GAUS, SC.D., ADMINISTRATOR, AGENCY FOR HEALTH CARE POLICY AND RESEARCH

Senator SPECTER. We will now turn to the second panel: Director of HCFA's Office of Managed Care, Bruce Fried; and Administrator of the Agency for Health Care Policy and Research, Dr. Clifton Gaus. Both Mr. Fried and Dr. Gaus represent agencies within the Department of Health and Human Services. Mr. Fried will present the administration's testimony and Dr. Gaus will be available for questions. All of the written testimonies will be included in the hearing record, as is our practice.

Mr. Fried, the floor is yours, and you may proceed.

Mr. FRIED. Thank you, Mr. Chairman. It is a pleasure to be here with you today.

I am going to conform my comments to those of the previous panel. I think I can draw from that discussion some of the chairman's interests in this area. Let me try to tailor my remarks to them, looking forward to a fuller discussion.

Clearly, through the evolution of the Medicare Program, the significant growth of managed care is a reality. As of November 1, 4.7 million Medicare beneficiaries had chosen managed care, as opposed to the traditional program. We are currently contracting with about 333 managed care plans.

The growth rate in Medicare managed care enrollment this year is approximately 30 percent, which is in line with the growth rate of last year and in previous years. The program is changing quite dramatically.

Notwithstanding the change, our objectives for beneficiaries, whether they are in fee-for-service or managed care, remain the same, which is to achieve the highest possible value. By value, I mean achieving the highest quality of care at the lowest justifiable price.

For beneficiaries, this is a new, and for many of them, unexperienced world from their working lives. We work very hard to inform beneficiaries of the consequences of their choices.

I have brought with me and submit for the committee's information a wide variety of informative publications that the Health Care Financing Administration is currently disseminating. In a number of our regions, we are publishing comparison charts between plans, which though rudimentary are important at this point in terms of allowing beneficiaries to compare premiums, benefits, and areas of a particular community that will be served.

I want to get into the comparison charts a little bit further down in my comments. Beneficiaries who enroll in a managed care plan are given or sent a notice from HCFA informing them about the consequences of their decision, about being locked in to a plan, that is, being part of a network, and about their opportunities to grieve and to appeal decisions that they are concerned about.

There is a large amount of other information that beneficiaries have received or have available to them and their organizations.

The work, frankly, has just begun. In the last year since I have taken on the responsibilities of the Office of Managed Care, there is an enormous amount of activity that we have going on.

Among these many things that we are doing is substantially expanding and increasing the protections of the appeals and grievance process. We will, we expect, before the end of next year publish new regulations that will afford greater and new appeals and grievance protections for beneficiaries who believe that a plan may not be providing them with care that they need. I can get into that in more detail during our talk.

HCFA has recently opened in Philadelphia the first mall-based "Your Medicare Store", where beneficiaries can come in to interact with HCFA professionals, gather information not only about the fee-for-service scheme, but about managed care options available in their community. Essentially, beneficiaries conduct business with the agency that is responsible for this program.

If we are going to address the whole swath of this area, one of the areas that we need to focus on is Medigap reform. It is an area where we believe legislation is necessary. Medicare beneficiaries enjoy a form of protection that no other patient in the population enjoys, and that is: the ability to choose every 30 days whether to remain in a managed care plan, change plans, or go back to fee-for-service.

One of the complexities for those choosing to return to fee-for-service is that they gave up Medigap, the medical supplemental insurance, when they enrolled in managed care. Indeed for most of them, when they return to fee-for-service, preexisting condition exclusions often apply in Medigap plans and act as an impediment.

We are in a market situation here. The market has been driven to a large degree, almost exclusively, in fact, by cost considerations largely from commercial purchasers. We in the Federal Government have to attend not only to the cost considerations, but to quality as well.

In that light, one of the questions must be: How do we measure quality? How do we know what plans are doing? There are three very important pieces of work that we are engaged in.

We have been working with other commercial and public purchasers, consumer groups, and we plan, through the National Committee for Quality Assurance, to develop HEDIS 3.0 that for the first time includes measures that are relevant to the Medicare population. This includes a very important measure of functional status that draws from much the same type of work in which Dr. Ware has been involved. This will allow us to look on a longitudinal basis at how plans maintain, improve, or have a decline in the functional status of the health of their patients, a very important piece of information.

We have worked very closely with my good friend and colleague, Dr. Gaus at AHCPR. His organization has taken the lead in developing a survey instrument that will be available not only to Medicare and to HCFA, but to all purchasers.

For us it is particularly important because it will allow us to require use of both HEDIS 3.0 and the survey by the plans that we contract with in the coming years. Beginning this calendar year, plans will be required to participate in the collection of this information and report the survey information on satisfaction, access, patient perception of quality of care to HCFA.

It is very important information, and what we do with this information is just as important. Our objective is to make the information available to beneficiaries so that they can make more informed choices among competing plans, and also to use it for our own management and oversight responsibility.

PREPARED STATEMENTS

Importantly, both with HEDIS 3.0 and with this beneficiary survey, we intend to implement them not just in the managed care context but in the fee-for-service setting as well. I see the red light is on. There are other areas I would like to get into. I will proceed if you like, or we could go right to questions if you would like.

[The statements follow:]

PREPARED STATEMENT OF BRUCE MERLIN FRIED

INTRODUCTION

Thank you for the opportunity to explain how the Health Care Financing Administration (HCFA) is working to ensure that Medicare managed care organizations are meeting the health care needs of Medicare beneficiaries. The changing demographics of our society will challenge health care providers and organizations to provide services to a population with longer life expectancy; i.e., decreased mortality and increased morbidity. To safeguard the interests of all members of our society, especially the most vulnerable, it is important that we clearly define and support measures to promote quality of care for beneficiaries enrolled in Medicare managed care plans.

This summer, we celebrated the 30th anniversary of the Medicare and Medicaid programs. Although managed care options have been a part of Medicare since the program's inception, the managed care program that we know today had its start in 1985 with the signing of the first risk contracts authorized under the Tax Equity and Fiscal Responsibility Act. Today, managed care is a major and growing part of the Medicare program. As of November 1, more than 4.7 million beneficiaries have enrolled in 333 Medicare managed care plans, two thirds of which are risk contracts. Risk plan enrollment for the first six months of 1996 increased by more than 520,000 beneficiaries—an annual growth rate of more than 30 percent. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent.

We have found that the managed care option is attractive to beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental—or "Medigap"—policies without paying a premium, although this may be due to inadequacies in our payment methodology. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, preventive benefits and prescription drugs, at little or no additional cost to the beneficiary. Beyond value measured in dollars and cents, managed care plans have the potential to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and wellness.

Our mission in HCFA is to serve our Medicare beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not enjoyed by most commercial enrollees. Let me take this opportunity to briefly outline the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

Beneficiaries receive clear and accurate information about the implications of their choice of a managed care option.—Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.

Beneficiaries can disenroll from a managed care plan on a monthly basis.—Current law requires that plans provide for the disenrollment of any beneficiary on the first day of the month following the beneficiary's disenrollment request. The ability of Medicare managed care plan enrollees to "vote with their feet" by disenrolling from a plan is one of the best methods we have to monitor quality of care, and to ensure beneficiary choice.

Beneficiaries cannot be subjected to health screening or pre-existing condition limitations.—Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.

Beneficiaries have access to medically necessary and appropriate care.—Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMO's adhere to these Federal standards.

Beneficiaries have access to procedures to resolve grievances and access to a neutral third party for appeals.—While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.

Beneficiaries' care is reviewed both internally and externally.—Plans must have internal quality review mechanisms in order to receive a contract. PRO's are responsible for external quality review. We have been working closely with other payors and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.

Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan.—Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.

Beneficiaries' out-of-pocket expenses are limited.—Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have been working toward enhancing beneficiary protections. Some steps can be taken under current law, other actions would require legislation.

—Improving the appeals and grievance processes.—The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary covered services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.

—Beneficiary information publications.—HCFA and its Department of Health and Human Services (DHHS) partners have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries. This was part of an outreach program directed at ensuring that beneficiaries are fully informed of their health care options.

—Comparative information.—We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's Fiscal Year 1996 Budget Plan, we proposed that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on

making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by March, 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements.

—Community-based Medicare information resource.—This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall and is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also be available, using technology such as interactive video-conferencing and computerized information kiosks.

—Medigap reforms.—While beneficiaries enrolled in managed care plans are assured open enrollment, only very limited open enrollment is required under Federal law for Medicare supplement policies. The federal requirement provides only a once-in-a-lifetime "window" for open enrollment in Medigap when a beneficiary turns 65. If beneficiaries are to have true choice, Medigap plans should at a minimum be open on an annual basis.

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

—Imposition of intermediate sanctions.—For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compliance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Department of Justice managed care fraud and abuse working group.—HCFA is an active participant in a federal workgroup led by the Department of Justice (DOJ) and composed of departments and agencies that contract with managed care organizations, e.g., the Office of Personnel Management, the Department of Labor (DOL), and the Department of Defense (DOD). The working group focuses on coordinating efforts among the various agencies to identify fraud and abuse in managed care organizations and develop methods to successfully prosecute suspected fraud cases. In addition, a Memorandum of Understanding among DHHS, DOJ, DOL, and the Treasury Department is being prepared to define the roles of each agency in the enforcement process.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements before we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties.

Physician Incentive Plan Regulations

Before I describe our efforts in the area of quality monitoring and improvements, I would like to address the need for regulations in regard to physician incentive plans.

Physician incentive plans are the financial arrangements between a managed care plan and its physicians. These plans are varied in structure. Some distribute per-

formance-based withholds or bonuses to physician groups. Increasingly, plans are using capitated payments to physician groups to transfer the risk of all specialty services or all services provided. Incentive plans are an important tool for managed care organizations not only in fostering the efficient delivery of care but also in reducing the risk of needless and intrusive procedures. However, it is important to recognize that the same incentive plan that may lead one physician to control over-utilization may influence another to reduce necessary care.

In legislation enacted in 1990, the Congress mandated that DHHS determine when an incentive plan would place physicians at substantial financial risk for referral services. The law does not prohibit physicians from being placed at substantial financial risk. It does, however, require that such plans provide "stop loss" protection to the physicians and conduct periodic surveys to monitor access to services and satisfaction with care. Final rules implementing the 1990 legislation were published in the spring of this year. In addition to defining substantial financial risk, these regulations require Medicare and Medicaid managed care plans to disclose to the Secretary the details of the incentive arrangements and upon request, provide the information to plan enrollees.

Since incentive arrangements are a major tool of managed care plans in controlling health care costs, they may be a concern to enrollees and health care purchasers to the extent that the arrangements are likely to have a negative impact on quality of care. Unfortunately, although HHS is actively working toward the development of outcome-based, quality measurement systems, such systems are not presently available. In the interim, the physician incentive plan regulations are a modest step to provide important protections to plan enrollees.

This past summer there were reports in the press that this Administration planned to shelve the physician incentive plan regulations. Nothing could be further from the truth. While the provision to provide stop loss insurance was to have gone into effect in May, all of the other provisions of the regulation will become effective with Medicare and Medicaid contract renewals on or after January 1, 1997. On May 28, we announced that the "stop loss" requirement would also go into effect beginning in January in order to conform with Congressional intent. This minor effective date change does not represent a "shelving" of the regulation. This Administration remains committed to a complete and vigorous implementation of the physician incentive plan regulations.

I would like to devote the rest of my testimony to describing the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, that is more elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for underservice and poor quality, if plans try to maximize short-term profits by not delivering appropriate care. The recent study by Ware et al, published in the October 2 issue of JAMA, indicated better outcomes in the study sites for elderly and poor, chronically ill patients in fee-for-service plans rather than managed care plans.[1] Other studies, however, have shown that the quality of care in managed care is as good or better than fee-for-service. While the work of Ware and his colleagues highlights the need for HCFA to pay special attention to the health care requirements of the chronically ill, the findings of previous studies should be also be considered. A fair summary of all available research is that managed care neither holds a demonstrable quality edge over fee-for-service nor provides inferior care.[2]

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[1] Ware, et al. Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems. JAMA, 276(13), 1996.

[2] Numerous studies relating to quality of managed health care have been done over the past decade, including the following (chronologically listed):

Cunningham, F. and Williamson, J. How Does the Quality of Health Care in HMO's Compare to That in Other Settings? The Group Health Journal, Winter, 1980.

The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee for service, and to determine whether managed care is living up to its potential to improve the quality of care.

HCFA and the Agency for Health Care Policy and Research (AHCPR) have been active in promoting research to identify these measures. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payors to accelerate and standardize the development of outcomes measures.

—HEDIS 3.0.—The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. Beginning January 1, 1997, HCFA will require certain types of health plans with Medicare contracts to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information.

HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the

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Shaughnessy, et al. A Study of Home Health Care Quality and Cost under Capitated and Fee-for-Service Payment Systems. Report prepared for HCFA by the Center for Health Policy Research, Denver, CO, February, 1994.

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first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the "effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.

—Foundation for Accountability.—The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the Facct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

—Medicare beneficiary satisfaction survey.—In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary customer satisfaction survey. This survey will quantify Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. It is currently being utilized in field testing as a tool for gathering standardized information from all plans, and is significant because it is the first survey specifically designed for Medicare HMO beneficiaries. This Medicare module is one of several CAHPS instruments and has 40 core questions that will make the instrument useful for both commercial health plan and Medicare beneficiaries. HCFA plans to require all health plans to use CAHPS by March 1997, when it will be available to the public. HCFA plans to administer the survey through an objective single third party vendor in order to ensure comparability.

—Medicare choices demonstration.—HCFA has taken the first step toward Medicare Managed Care choices by demonstrating how the program can be expanded to include PPO's and PSO's. Managed care plans in urban and rural settings were chosen to participate in this demonstration, which solicited innovative managed care proposals encompassing alternative point-of-service and payment methodologies and case management systems. A component of the demonstration is the development of quality measurements systems that will use encounter data; all participating plans will be required to provide 100 percent encounter data. Simply stated, encounter data refers to the reporting of information on health care services received by enrollees. Currently, we have concluded a contract with the RAND Corporation to assist HCFA in designing an encounter data based quality monitoring system, which will be developed further using the Choices demonstration encounter data. Of 372 proposals, 25 were selected and are in the final stages of the contract award process; beneficiaries should be able to enroll in these plans in 1997.

In addition to our activities in measuring quality of care, we are actively involved in promoting quality improvement.

—Projects to assess ambulatory care in managed care settings.—The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PRO's in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMO's are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PRO's in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.

—Social health maintenance organizations (SHMO's).-The second generation of SHMO demonstrations includes an expanded case management system de-

signed to address the medical social, functional, and environmental needs of enrollees. All participants must establish a quality assurance system under which care will be monitored through chart audits, statistical reports, grievances, and outcome measures. This demonstration also anticipates our nation's changing demographics by offering geriatric-oriented care and limited long term care services. Risk adjustment will be an important component of this demonstration, and all regions of the country will be represented.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs.

CONCLUSION

Managed care as a health care system is here to stay, but Medicare beneficiaries themselves must determine the pace of the program's movement to managed care. The emphasis must be on choice. Millions of beneficiaries have already voted with their feet for this option. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. We expect that in the very near future we will be seeing some tangible benefits from this agenda.

PREPARED STATEMENT OF CLIFTON R. GAUS

Good morning, Mr. Chairman and members of the Subcommittee. I want to thank you for giving me this opportunity, as the Administrator of the Agency for Health Care Policy and Research (AHCPR), to discuss the issue of quality health care and the role that health services research is playing to assure that we can measure and improve the quality of care that Americans receive.

There are four major points that I want to leave you with today:

First, because our health care system is market-driven, information—about quality as well as cost—is absolutely essential for the market to work. Without objective, credible information, consumers, health care professionals, purchasers, plans, and payers cannot make informed choices or assess the real value of health care services.

Second, while we do not have all of the answers we need today, Congress' investment in health services research over the last 25 years has provided us with much of the science and many of the tools we need to measure and improve the quality of health care services.

Third, we know that there is a huge gap—in day-to-day clinical practice—between what we know and what we do. We need to narrow that gap and to build the evidence base for improving day-to-day clinical practice.

Fourth, the good news is that our research demonstrates that better quality can often cost less and that more care is not always better care.

THE NEED FOR QUALITY INFORMATION

Mr. Chairman, the demand for quality information is growing in all segments of the marketplace. Consumers need better information so that they can choose the right health plans, the right health provider, and the best clinical treatment for their particular needs. Similarly, health professionals—who are inundated with new scientific findings on a daily basis—need better, more efficient ways to stay on top of the latest advances in clinical science so they can practice "modern" evidence-based medicine. In addition, public and private-sector purchasers and policymakers need better information to assure accountability. Let me just say a word about each.

Two weeks ago, our agency and the Kaiser Family Foundation (KFF) released the results of the first nationally representative survey of Americans' need for and use of information regarding the quality of health care. The survey found that a large majority of Americans (nearly 90 percent in every case) felt that quality information—such as how a plan cares for members who have health problems, ease of getting needed care, and success at early detection of disease—was "very important" to know when choosing a health plan. Moreover, about half of all Americans—more

than 38 percent of Medicare beneficiaries—believe that there are "big differences" in the quality of care among health plans.

The overwhelming majority of Americans felt that quality was important to them and almost one-half felt quality was far more important than cost, choice of physician, or even the range of benefits. And, while most of those persons who have seen information comparing quality said it would be useful in making choices, far fewer said they had used it in their own decisionmaking. In fact, most of the respondents admitted that they relied upon recommendations of friends and families and their personal physician over that of experts.

The simple fact is that there are few sources of credible, unbiased information upon which Americans can rely. But the demand for such information is strong. More than 88 percent of respondents in the poll thought government should have a role in quality. A majority said government should make sure that information about quality is publicly available and that government should set minimum standards for quality of care in the same way that government safeguards the food supply. Our experience in working with the state of Oregon on their health plan Report Card project also suggests that information is often not enough; consumers need help in understanding and interpreting the information they are given. This is especially true for populations at risk, such as the populations served by Medicare and Medicaid.

Health services research has also demonstrated that patients want more information from their physicians and health care professionals. An increasing number of patients want to participate more actively in medical decisions regarding their own care and it can actually improve the clinical outcomes for patients. In a series of reports from the Medical Outcomes study—the same project from which Dr. Ware's paper is drawn—Dr. Sherrie Kaplan of the New England Medical Center found that patients of physicians who practiced participatory decisionmaking had better clinical outcomes when she and her colleagues looked at such factors as diabetes control, blood pressure, arthritis severity, and functional status among patients with chronic disease. And this does not even consider the economic benefits to physicians because patients are less likely to change doctors or file a malpractice case.

Health professionals face conflicting pressures. For example, in the not-too-distant past, physicians seldom found their professional judgment second-guessed. Today, clinicians are increasingly being asked to cite the scientific evidence that supports a proposed course of treatment for a patient. But as the Director of the National Library of Medicine has noted, it is a daunting task to keep abreast of the ever-changing medical literature. He calculated that if a physician read two peer-reviewed journal articles each night that, at the end of a year, he or she would be 800 years behind in his or her reading. I am pleased to say our agency is working on solutions to this problem as part of our fiscal year 1997 budget which your committee supported. We will be able to establish a network of Evidence-based Practice Research Centers that will provide clinicians with readily accessible syntheses of the available scientific evidence. Our centers will read and evaluate the thousands of journal articles and summarize the findings in a clear and concise format for the busy clinician to use.

Similarly, purchasers and policymakers are pushing the movement for greater accountability. Organizations such as NCQA, JCAHO, and the FACCT are pushing for quality measurement development and reporting by major health care plans, the adoption of quality assurance systems, and the reporting of enrollee satisfaction. Employers and large purchasers are beginning to make decisions on which health plans to offer based upon this information and this trend is expected to escalate. The participation in these efforts by HCFA, DOD, OPM, and other federal purchasers is an important and progressive step.

THE SCIENCE AND TOOLS TO IMPROVE QUALITY

Mr. Chairman, while we have much more work to do in developing the science and tools for quality measurement and improvement, it is important to recognize that we have come a long way in this area. And this progress has made possible the recent work of John Ware and his colleagues at the New England Medical Center. Health services research has developed and validated the tools for patient self assessment of health status, provided us with functional outcome measures for patients, and patient satisfaction indexes. It has also provided us with a wealth of quality measures, particularly in hospital settings and for acute care problems. However, we particularly need more quality measures that address the chronic problems faced by many Medicare beneficiaries and we need to confront the complexity and cost of retrieving this data from often antiquated paper-based medical records.

In attempting to put these developments into perspective, I think it is helpful to think of this process as akin to building ever more powerful microscopes—microscopes that enable us to examine the quality of health care in increasingly finer detail. It is clearly still a work in progress; we are far from having an "electron microscope"—my analogy for having all of the tools we need to perfectly measure and improve quality of care. But with each passing year, we are better off.

However, the analogy also raises a significant caution. As we develop more powerful and effective quality tools, it is important to recognize that we may see more and more flaws in the process and delivery of health care services—ones that we never recognized before. As a result, we need to be careful about assuming that there is blame to be assessed and we need to be careful in our efforts at comparisons.

Refining the microscope is only half the battle. It will only let us see the flaws in our system more clearly. It does not address the challenge of quality improvement: how we can improve our systems of care. Quality experts overwhelmingly conclude that we are not doing the best we can, that we are capable of a much higher standard of care, and that we need to focus on what will get us there. Health services research, both public and private, is helping to close this gap between what we know and what we do.

CLOSING THE GAP BETWEEN WHAT WE KNOW WORKS AND WHAT WE DO

When AHCPR was first established in 1989, Mr. Chairman, we gave the highest priority to our new mission to build the science base underlying day-to-day clinical practice. Biomedical research had a long track record of identifying potential causes and cures of disease through the use of bench research and clinical trials of carefully screened patients. We were asked by the Congress to go the next step and assess the effectiveness of these interventions in day-to-day clinical practice. Our research asked simple but important questions: is the clinical intervention effective in day-to-day practice? What does it cost? And how widely is it used?

What we have concluded from this early work is that there are many effective interventions to improve quality and outcomes and often lower costs but they are not uniformly practiced. Put another way, there are clearly tremendous opportunities for improving the quality and effectiveness of clinical services by simply putting into practice what is already known. I do not mean to suggest that we can abandon our efforts to build the science base but there are opportunities for significant improvements in the short-term. Let me cite a few examples, some very relevant to the Medicare program:

—We know that anti-coagulation therapy for the elderly with atrial fibrillation will prevent strokes in older Americans. Yet fewer than 25 percent of eligible patients receive the treatment and, of those who do, almost half receive the wrong dose. If anticoagulation therapy was available and used by patients at risk, we could prevent 40,000 strokes a year and save $500 million a year.

—Urinary incontinence affects 15 million Americans, most of them elderly women, and it is a primary reason that they enter nursing homes. Yet 80 percent of these cases can be treated or cured by following existing scientific knowledge. With direct health costs total $11.2 Billion and $5.2 Billion in nursing home expenditures, the potential for savings is enormous.

—We know how to prevent pressure ulcers yet nearly 10 percent of hospital patients and 25 percent of nursing home patients suffer unnecessarily from pressure sores. This is a vital health issue for Medicare, because patients with chronic disease are at great risk for developing pressure ulcers. And we know the savings potential is enormous; Intermountain Health Care in Salt Lake City reported savings of $240,000 over just 6 months at just one hospital.

—Perhaps no other problem is more insidious in its impact on the cost and quality of inpatient care that unrelieved patient pain. Over 23 million operations a year involve some form of pain management but half of those efforts were ineffective. Yet effective pain management is possible and it contributes to shorter hospital stays, earlier mobilization, and results in lower costs. One hospital succeeded in reducing hospital length of stay by 35 percent as a direct result of applying pain management techniques.

—If we believe that Quality should truly be "Job One," shouldn't our goal be that all operations have a pain management protocol that is effective?

One area in which Medicare has already seen savings is in the rate of surgical interventions to treat Benign Prostatic Hyperplasia (BPH). BPH affects more than 50 percent of all men over age 60 and about 8 out of 10 men by age 80. Until recently, transurethral resections of the prostate (a TURP operation) was recommended for patients with initial symptoms of BPH, making it one of

the most common surgical procedures paid for by Medicare. Outcomes research has demonstrated that initial symptoms do not always lead to serious problems and that rate of complications—incontinence, impotence, infection, and need for reoperation—was much higher than the research literature had demonstrated. As a result, rates have begun to fall as more physicians encourage patients to delay ("watchful waiting") surgery and these falling rates saved Medicare over $100 million between 1992 and 1993.

—We also know that we can improve the quality of care and lower costs by re-engineering our systems for delivering care. We need systems that help clinicians to do their best. For example, nearly two years ago, one of our grantees from Harvard University, Dr. Lucian Leape, found that between 2 percent and 14 percent of patients admitted to hospitals get the wrong medication because hospitals do not have information systems in place to avoid human errors, such as miscommunication between physicians, nurses, and hospital pharmacies. Similarly, the Harvard Medical Practice Study found 4 percent of patients in the state of New York suffered iatrogenic injury, mainly caused by medication errors, that increased their stay in the hospital or caused a measurable disability or death. In an article in JAMA Magazine, Dr. Leape noted, that if these rates were the typical nationwide, 180,000 patients die each year as a result of iatrogenic injury, mistakes of the process of care.

A month ago, we joined the AMA, the AAAS, and others in sponsoring a conference, Examining Errors in Health Care, which was designed to build upon Dr. Leape's work and set the stage for additional research in the re-engineering of our systems of care. As Dr. Donald Berwick, a leader in the field of quality improvement notes, we need to structure our health care systems so that the easiest course of action is the right one for the patient.

These are two areas—applying our existing clinical knowledge and improving the organization of our health care systems—in which research has demonstrated the prospects for significant improvements of quality in the short run.

CONCLUSION

As you can see, we can congratulate ourselves on some very significant progress in the field of quality measurement and improvement. These examples demonstrate, Mr. Chairman, that improved clinical quality can often increase patient satisfaction and lower costs as well. In sum, better quality can cost.

I look forward to working with the subcommittee to reach this goal.

BIOGRAPHICAL SKETCH OF CLIFTON R. GAUS

Dr. Gaus is Administrator of the Agency for Health Care Policy and Research (AHCPR) in the Department of Health and Human Services.

AHCPR supports research designed to improve the quality of medical care and lower costs by investigating what works and what doesn't work in the health care system. Through its support of health services research, Evidence-based Practice Centers, and technology assessments, the Agency translates biomedical research into science-based information for use by patients, medical practitioners and purchasers of health care.

Dr. Gaus has a diverse background in health care policy and research, with broad experience in government, academia and the private business sector. He has served in senior health positions under Presidents Nixon, Ford and Carter, as well as in the Clinton Administration.

As co-founder and past President of the Association for Health Services Research, Dr. Gaus served on the Association's board for nine years. He has also served in a number of consulting roles with health care companies. In the late 1970's, Dr. Gaus was Associate Administrator for Policy, Planning and Research for the Health Care Financing Administration (HCFA).

Dr. Gaus has held faculty positions at The Johns Hopkins University School of Public Health and at Georgetown University Medical School. He holds a master's degree in health administration (M.H.A.) from the University of Michigan, and a doctorate of science (Sc.D.) from The Johns Hopkins University.

Senator SPECTER. Thank you very much, Dr. Fried. Let us proceed now to the dialog, and perhaps you can integrate some of the other items you have in mind. I will give you an opportunity at the conclusion of your testimony to cover anything that you feel we have missed.

Mr. FRIED. Thank you, sir.

Senator SPECTER. You heard the testimony of Dr. Ware about the need for more information. Would you concur with that?

Mr. FRIED. Absolutely.

Senator SPECTER. Do you think Federal legislation is necessary on that subject?

Mr. FRIED. I do not think that it is at this point; although, I might want to revisit that thought. We have——

Senator SPECTER. How do you get to the requirement of the specification of the information needed without Federal legislation?

Mr. FRIED. Section 1876 of the Social Security Act gives the Secretary authority to require plans to provide whatever data may be necessary for us to determine——

Senator SPECTER. What action has been taken by the Secretary pursuant to that provision?

Mr. FRIED. There are two actions that I just mentioned in my comments. We have informed plans that the HEDIS 3.0 data set will have to be collected by the plans and reported to HCFA in the coming contract year beginning January 1.

Senator SPECTER. Well, that is according to HCFA. But, what goes to the prospective client?

Mr. FRIED. If I could finish my statement for a moment.

Senator SPECTER. Yes.

Mr. FRIED. The other is the survey instrument that Dr. Gaus' organization has developed. The data for both of those instruments will be collected by us and reported to beneficiaries. We are working toward being able to report comparable information——

Senator SPECTER. Now, when you report that to beneficiaries, what does that do specifically about requiring plans to be specific on information which you think beneficiaries need?

Mr. FRIED. Well, if I could describe the HEDIS 3.0 instrument, for instance, it is a very comprehensive measure of approximately 75 different elements that cover everything of importance to our population, such as the frequency of immunizations, the incidence of mammography for women over age 65, and the incidence of retinopathy of eye exams for Medicare beneficiaries with diabetes. In our mind perhaps most important——

Senator SPECTER. You are specifying what they need to do for the patients?

Mr. FRIED. Well, HEDIS 3.0 is a set of measures that a group of scientists essentially have identified as those things that a health plan would have to do in order to have successful outcomes of care. It is admittedly not a measure of the outcome itself, but of those indicators that a plan must——

Senator SPECTER. Do you specify how long a woman has to stay in the hospital after delivering a child?

Mr. FRIED. No, sir; they do not.

Senator SPECTER. Do you think that is excessive micromanagement?

Mr. FRIED. I do.

Senator SPECTER. Or, maybe just that is redundant micromanagement?

Mr. FRIED. I think I would——

Senator SPECTER. The management that you undertake is not micromanagement; right?

Mr. FRIED. Well, I think what we are proposing are performance measurements as opposed to actual kinds of things that plans have to do. Let me answer the question this way, Senator.

Senator SPECTER. Well, you are specifying what plans have to do.

Mr. FRIED. We are asking the frequency with which they are doing these things.

Senator SPECTER. You are raising the question, you are not imposing a requirement?

Mr. FRIED. We are requiring plans to report certain kinds of performances that we will use both for our management oversight and to report to beneficiaries so that they can make informed choices.

Senator SPECTER. Well, does your organization tell prospective enrollees what the companies are doing, or do the companies themselves tell prospective enrollees what they will do?

Mr. FRIED. If I understand your question, sir, at this point we do not have the information that I have just described. In the coming calendar year, we will be providing that information to beneficiaries.

Senator SPECTER. What you are saying is right now there are no requirements as to what the managed care companies have to tell their prospective enrollees, people whom they are soliciting?

Mr. FRIED. In their marketing materials, there is a great deal of information that they must provide in terms of copayments, the benefits that are covered above and beyond those that are normally covered by the Medicare program, areas of service, the physicians that are in the network, the hospitals that are in the network, all of those kinds of information are part of what is required to be reported.

Senator SPECTER. The long and short of it is you do not think any legislation is necessary now, but you might want some?

Mr. FRIED. I believe currently we have the legislative authority to require plans to report the kind of information we are intending to collect.

Senator SPECTER. Do you ask managed care plans whether the plan has a so-called gag clause in contracts with providers?

Mr. FRIED. No, sir; we do not.

Senator SPECTER. Do you think you should?

Mr. FRIED. The President has said quite clearly that he believes that gag clauses, or any impediment to physicians being able to fully counsel their patients, is wrong and should not be permitted. I believe that the Department will be sending up in its legislative package provisions that preclude any managed care organization from having such a provision in its contracts.

Senator SPECTER. The answer is yes?

Mr. FRIED. Yes.

Senator SPECTER. Because the President says so?

Mr. FRIED. Indeed.

Senator SPECTER. Are you now asking that question?

Mr. FRIED. No, sir; we are not.

Senator SPECTER. Why not?

Mr. FRIED. It has not been an issue that we have been confronted with in our review of appeals.

Senator SPECTER. How long ago did the President make his statement?

Mr. FRIED. I believe the President's comment was about 4 or 5 months ago. I do not recall with precision.

Senator SPECTER. Well, does that not confront the issue?

Mr. FRIED. Again, I think the answer to the question, sir, is that in our oversight of managed care organizations and our review of the issues that people are seeking to appeal, we have not identified any instance that a gag clause has been used in a way that has had an impact on beneficiaries.

Senator SPECTER. Well, but you are not asking the managed care plans whether the plan has a gag clause?

Mr. FRIED. No, sir; we have not.

Senator SPECTER. Well, why do you not ask them that?

Mr. FRIED. I believe that for the coming year we will be doing that.

Senator SPECTER. Well, why are you waiting?

Mr. FRIED. We have a contract that exists through the end of this year, and the terms of the contract are what they are.

Senator SPECTER. You have a contract which is in existence. The contracting parties are who?

Mr. FRIED. The Health Care Financing Administration and particular plans, the plans that we contract with.

Senator SPECTER. That is done on an annual basis?

Mr. FRIED. Yes, sir; that's right. January 1 begins the contract year.

Senator SPECTER. There is no way to add something where there is a major matter which arises like the so-called gag clause?

Mr. FRIED. Again, Senator, I think the question is, "have we seen this as a problem?"

Senator SPECTER. No; I am on a different point now. I am on a point as to whether or not you can make an addition to a contract where there is a major public policy problem.

Mr. FRIED. I am sure that there would be a way to do that.

Senator SPECTER. Well, why do you not do it?

Mr. FRIED. I will take that under consideration. The question is whether at this point, with January 1 being only 6 weeks away, whether it may take us that much time to get to that point.

Senator SPECTER. It takes you 6 months to——

Mr. FRIED. Six weeks.

Senator SPECTER [continuing]. Six weeks to get to that point?

Mr. FRIED. Well, we are going to have a new contract in 6 weeks, Senator.

Senator SPECTER. Well, that is a long time for a lot of people and a lot of care. Why have you waited until now when the President spoke, as you testified, 4 or 5 months ago?

Mr. FRIED. I can only say, sir, that as we have administered the program and overseen the plans we have not identified a single instance, to my knowledge, where this has had an impact on Medicare beneficiaries.

Senator SPECTER. Well, there are two points: one point is whether it is a significant point, and the second point was whether or not you have the authority to do something about it before January 1.

On the point that you keep coming back to, that you have not identified a real problem, the Congress and the Senate has voted on it. That may not amount to too much. But the President has spoken about it. He is the chief executive officer directing your Department. I find it hard to understand why you do not respond to the President, Mr. Fried. Why not?

Mr. FRIED. Senator, I can only say that we are moving forward with this, and it will be part of our operation of the program in the future.

Senator SPECTER. Well, Mr. Fried, I do not consider that you are moving forward with it when it has been identified by the President 4 to 5 months ago, and I do not consider it adequate to delay it for 6 weeks if there is something that you can do about it now. I think there needs to be a lot more sense of urgency in what we all do in the Government. Six weeks is a lot of time for a lot of people to die.

What is your evaluation of the issue as to whether the profit motive is excessive and discourages managed care plans from giving the kind of specialty care which is warranted?

Mr. FRIED. The answer is a fairly complex one.

Senator SPECTER. Well, try me.

Mr. FRIED. The payment mechanism that we currently employ, the one that the statute articulates, requires a reconciliation between (1) the estimated average amount that HCFA would pay based on the AAPCC, which is 95 percent of what we estimate it would cost for us to provide care on the fee-for-service side in a particular county, with (2) the adjusted community rate [ACR] for that plan, which is what the plan estimates Medicare benefits would actually cost in the particular community.

The difference between the average payment rate and the adjusted community rate payment must be returned either to the Treasury or to beneficiaries in the form of additional benefits.

Within this process, there is a calculation that accounts for the administrative costs including profit that the plan makes. My understanding, from the analyses that I have seen, is that the profit derived from Medicare managed care is about 2 percent.

I cannot speculate on what the situation is in the commercial sector. Having answered your question at length at this point, if I can recall your question properly, I do not know of any concern that care is being constrained or limited in some way based on a profit consideration, at least not in the Medicare program.

We are engaged in a variety of actions to look at some of the issues that you have raised with the earlier panel.

For instance, the question arose in earlier discussions about what incentives plans may have for physicians that would wrongly encourage them to avoid providing necessary care.

We have published a final regulation with comment addressing the issue of physician incentive or payment incentive plans between managed care organizations and physicians or physician groups.

In doing so, we worked hard to strike the balance that Congress asked us to between their wanting to avoid care that was unnecessary to excessive care being wrongly provided.

We wanted to avoid unnecessary care on one hand, but also limit the degree to which plans can provide incentives that would unnecessarily or wrongly preclude care that is necessary.

One provision of that regulation makes it absolutely illegal for a plan to have a specific payment arrangement with a physician to preclude care to a specific patient. Obviously, no one would stand for that. That regulation is out and will be fully implemented January 1.

Senator SPECTER. Mr. Fried, The New York Times reported on July 8, that there was at least a delayed implementation of new rules that would have restricted an HMO practice of rewarding doctors who cut costs and control services to Medicare and Medicaid patients; is that correct?

Mr. FRIED. No, sir; Mr. Pear, who was the writer of that article, was wrong. If I could——

Senator SPECTER. What is the fact?

Mr. FRIED. The fact of the matter is the rule was published in final with an opportunity for comment in, I believe, March.

Mr. GAUS. Yes.

Mr. FRIED. At the time of the publication, when we briefed consumer and physician organizations, plans, and the press, we acknowledged that we had identified at the last minute a problem with one aspect of the implementation schedule, and that we would have to be refining it.

The one issue was the date by which stop loss insurance would have to be provided for physicians in these contractual relationships. The terms of the statute had the implementation date coincide with the contract year, January 1.

The regulation as published had that wrong, frankly. It was my decision that this was too important a regulation to hold the whole thing up while we got this specific fine point resolved.

Senator SPECTER. What is this fine point again?

Mr. FRIED. Well, it is more than a fine point. It is obviously an important piece of the regulation, that stop loss insurance must be provided for physicians whose incomes are at substantial risk. Substantial risk is defined as more than 25 percent of their income being at risk. For those physicians, stop loss insurance must be provided, essentially protecting their income level.

Senator SPECTER. Precisely what is stop loss insurance?

Mr. FRIED. Stop loss insurance will essentially hold the physician harmless if they recommend the care outside of the practice, specialty referrals, for instance, that in so doing would place more than 25 percent of their income at risk.

Senator SPECTER. If they make that recommendation, they will have a lower income from the managed care company paying them?

Mr. FRIED. The purpose of a stop loss insurance is to hold them harmless from having their income affected.

Senator SPECTER. They have to come to a loss of at least 25 percent of their income before the stop loss insurance applies?

Mr. FRIED. That was the balance that was struck, yes, sir.

Senator SPECTER. If they have a 20 percent loss, the insurance does not apply?

Mr. FRIED. Yes, sir; that is correct.

Senator SPECTER. That is a pretty big risk factor for a doctor to undertake, isn't it? It might discourage him from making a specialty referral?

Mr. FRIED. Your point is one we are discussing. We took some time in developing the regulation. Frankly, it started long before I came on board and took this responsibility. There was a lot of actuarial work done.

The question was, How do we strike the balance between permitting plans to create incentives to avoid unnecessary care and avoiding the incentive to deny patient care that is necessary?

I was not here at the time, but my understanding is that when the regulation was originally in development a small number of physicians and I do not remember the exact number would have been protected by the regulation. My understanding now is that the regulation is going to have significant protection for large numbers of physicians.

Senator SPECTER. That regulation is not in effect at the present time?

Mr. FRIED. The regulation is in effect, except for the requirement that stop loss insurance be provided. As I say, that will become effective January 1, 1997, as part of the new contract.

Senator SPECTER. How long has the stop loss insurance provision been suspended?

Mr. FRIED. Well, I would say, Senator, that the terms of the legislation required us to provide the stop loss insurance effective with the contract year, so I would not say it was suspended at all. I would say we are acting in consort with the terms of the legislation.

Senator SPECTER. Well, there has not been stop loss insurance since when?

Mr. FRIED. Many plans provide stop loss insurance, so I cannot tell you the number. But if the question is in terms of the regulation——

Senator SPECTER. The regulation does not require stop loss insurance?

Mr. FRIED. The regulation requires stop loss insurance effective January 1, 1997. The regulation was published in the middle of March of this year with a period for comment.

Senator SPECTER. When could the stop loss regulation have gone into effect?

Mr. FRIED. The statute provided that it would go into effect on January 1 in concert with contract years.

Senator SPECTER. It could not have gone into effect any earlier than January 1, 1997?

Mr. FRIED. That is my understanding of the terms of the legislation, yes, sir. Now, let me just say——

Senator SPECTER. When you say your "understanding of the terms of the legislation," is there any ambiguity in the legislation?

Mr. FRIED. I do not believe that there is. That is certainly my understanding of it.

Senator SPECTER. Wasn't this legislation enacted with OBRA in 1990, Mr. Fried?

Mr. FRIED. Yes, sir; that is right.

Senator SPECTER. The rule is that "no specific payment is made directly or indirectly under a plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee"?

Mr. FRIED. That provision of the statute, I believe, is self-enforcing. No regulation was necessary to make that effective. I believe that provision of law is in force and has been since the enactment of the legislation, or since the implementation of the legislation.

Senator SPECTER. There is no plan which limits a specific payment relating to induce or limit medically necessary services?

Mr. FRIED. Not that I am aware of, that is right, that is illegal.

Senator SPECTER. The provision here that "Prepaid health care organizations may operate a physician incentive plan only if," and the second provision is, "for arrangements that cause substantial financial risks, stop loss protection, enrollee survey, and disclosure requirements are met"? That has not been met?

Mr. FRIED. Yes, sir; that is effective. In all instances, the effective dates are clear. Again, the one implementation date——

Senator SPECTER. The implementation date is when?

Mr. FRIED. Well, it is a complicated regulation. There are portions that are in effect now and portions that become effective with the contract year, January 1.

Senator SPECTER. Of what year?

Mr. FRIED. 1997.

Senator SPECTER. Well, what has taken so long since 1990 when OBRA was passed?

Mr. FRIED. Congressman, I wish I could tell you. I came on and took responsibility for this part of HCFA September 18, 1995. It is a complicated regulation. There was an enormous amount of work done. There was substantial comment received when the proposed regulation was issued. There was actuarial work that had to be done. I agree with you. Senator, it took too long a time for this regulation.

Senator SPECTER. You think it took too long from 1990 to now?

Mr. FRIED. Clearly. I think we all know that the APA process is burdensome and complicated, and certainly that showed up in this instance.

Senator SPECTER. Well, this is a very long subject, and we may have to have another hearing on it, but I would like you to address it in writing, the substance of this New York Times article of July 8, 1996.

Mr. FRIED. I would be delighted to do that.

Senator SPECTER. We can have your response in writing, and we will take it from there.

Mr. FRIED. I would be happy to do that.

[NOTE.—The response will be retained in committee files.]

Senator SPECTER. Is there anything else you care to add at this time?

Mr. FRIED. Well, I do feel compelled to say this, Senator. As I said, and if I am redundant, please forgive me, but I cannot tell you how important I believe the work is that we and our colleagues at AHCPR are involved in.

The health care system is clearly reacting to market forces. The incentives that commercial purchasers have set have been incentives to constrain the growth of health care costs.

I think commercial purchasers recognize that the Federal Government has not been successful at constraining the growth rate of health care costs. You may recall when Lee Iaccoca appeared before the Labor Committee in 1986, I believe it was, and noted for the first time that the cost of health care exceeded the cost of steel in his automobiles. That was an alarm bell that we should have all heard.

Commercial purchasers set an economic objective for the health care system. For managed care organizations, it was essentially to save us money. Managed care organizations with that incentive in mind have been quite successful.

HCFA is the largest purchaser of managed care in the country. We have an objective that certainly has to be about cost. I think the Congress will certainly engage that issue in the coming year, but we have to be at least as concerned about quality as we are about costs.

From my perception, I think our responsibilities are even more so on the quality side. This includes work that we are doing in terms of the development of HEDIS 3.0, working with AHCPR in the development of this beneficiary survey, working with other public and private purchasers in the development and implementation of true measures of outcomes.

How well plans succeed at meeting the health care needs of patients with specific problems is ground-breaking work. It responds precisely to the kinds of encouraging statements that Dr. Wilkensky and Dr. Ware made in the preceding panel.

We are doing this; we are going to have an ability for our beneficiaries to access data about how plans compare to each other so that they can be part of changing the economic incentive structure.

Plans want beneficiaries. They want them desperately. Beneficiaries right now basically are making decisions based on cost, on what their neighbor next door thinks. We want them to have quality information so that they can make these choices as well.

The more interesting question, Senator, is: What can we as the Federal Government do to use these quality indicators not just for management and oversight. We can certainly do that, but can we use this information to make purchasing decisions? There are some private sector organizations that only purchase from certain managed care organizations that get over certain quality thresholds.

Senator SPECTER. Mr. Fried, would you address the question as to what legislation you think is necessary for Medigap? You had stated that at the outset.

Mr. FRIED. Yes, sir; I would be happy to. We will be submitting a legislative proposal that would preclude Medigap insurers from employing a preexisting condition exclusion, and that they have at least a period each year when there is open enrollment.

Senator SPECTER. Well, we are going to pursue this, Mr. Fried. Let me just say to you that I consider your position totally, totally unacceptable on two items that I have heard about today: One is the so-called gag rule, where the President identified the problem

4 to 5 months ago, and the Senate has acted and you have not acted to change that.

You concede in your testimony that there are ways you could address it, even though you have a contractual provision here. Contracts are subject to change by governmental action where important public policy issues are involved. Four to five months plus 1½ months, 6 months-plus is totally unacceptable. I do not know why the President let you get away with it.

From November 13 to December 31 is a long time. You ought to act on it today. You ought not let any time pass. I have been a patient fairly recently, and have a very, very high regard for a day, let alone 48 days, which is how many there are between now and December 31. You ought to act on it today.

[NOTE.—The following policy memorandum was sent by HCFA to its Medicare managed care contractors on November 25, 1996, stating gag rules are a violation of the law.]

MEMORANDUM FROM THE OFFICE OF MANAGED CARE

NOVEMBER 25, 1996.

Subject: Physicians' Advice and Counsel to Beneficiaries Enrolled in Medicare Managed Care Plans

Question. Are Medicare beneficiaries enrolled in managed care plans entitled to advice and counsel by their physician of medically necessary treatment options that may be appropriate for their condition or disease?

Answer. Yes. Medicare beneficiaries who are enrolled in a Medicare contracting risk or cost plan are entitled to the same benefits that they would be entitled to under the fee-for-service (FFS) program. See section 1876(c)(2)(A) of the Social Security Act.

Among the benefits to which FFS beneficiaries are entitled is advice and counsel from their physician on medically necessary treatment options that may be appropriate for their condition or disease. Beneficiaries enrolled in a Medicare managed care plan are, likewise, entitled to such advice and counsel from their physician.

Consequently, a physician providing care to a Medicare beneficiary under the terms of a risk or cost contract may not be limited in counseling or advising the beneficiary of medically necessary treatment options that may be appropriate for the individual's condition or disease.

Contractual provisions that limit a physician's ability to so counsel or advise a Medicare beneficiary are a violation of the law. Assuring the availability of this benefit to Medicare beneficiaries will be part of HCFA's routine oversight of contracting managed care organizations.

Senator SPECTER. On stop loss protection, where it really involves what doctors may limit their advice to patients as to what specialty care they need, and their income is at risk up to 25 percent, not to have the stop loss issue dealt with since 1990, again in my judgment, is just totally unacceptable and totally inexcusable. I would be glad to hear any response you want to make at this time.

Mr. FRIED. With the second issue, certainly I am not in a position to defend the time that it has taken from the date that the legislation was enacted. I would just simply note that since I have come on board, this regulation has moved with a great deal of dispatch.

Senator SPECTER. Well, when did you come on board, Mr. Fried?

Mr. FRIED. September 18, 1995.

Senator SPECTER. Well, that is 1 year and 2 months.

SUBMITTED QUESTIONS

Mr. FRIED. We published the final regulation that had been pending since 1990. Senator, again I am not here to defend the amount of time it has taken except to note that——

Senator SPECTER. When can you get it finished?

Mr. FRIED. January 1, sir.

Senator SPECTER. OK. Thank you very much.

[The following questions were not asked at the hearing, but were submitted to the Administration for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR SPECTER

Question. Mr. Fried, what is Phase II of your comparative information project? When will it be completed?

Answer. The Health Care Financing Administration is in the process of establishing a database with information about Medicare health plans which will eventually be available on the Internet. The information will include a comparability chart to help beneficiaries make informed choices regarding the available Medicare managed health care plans. Phase I of this effort will provide comparative data on HMO benefits, premiums, and cost sharing in a specific market. Phase I is expected to be implemented in March, 1997.

Phase II of the project will include beneficiary satisfaction, plan performance, and quality of care comparisons on a market-by-market basis. In addition to the standardized reports, the system will allow users to obtain more customized information. Phase II of this project will fit the database with a graphics interface to allow easy access via the Internet. The products will be available for downloading for use in counseling or decision making, and for publication by mass media, advocacy groups and others. Phase II is expected to be in limited use by the Fall of 1997.

Question. Mr. Fried, under the traditional Medicare program what preventive services are covered?

Answer. Title XVIII of the Social Security Act provides for coverage of several preventive health services under Medicare, including pneumococcal, hepatitis, and influenza vaccines, screening mammography, and pap smears.

Question. What services are covered under Medicare managed care?

Answer. Section 1876(c)(2)(A) of the Social Security Act requires that managed care plans contracting with Medicare provide the same services that are covered under Medicare Part A and Part B. HCFA may also approve the provision of additional benefits and services to beneficiaries enrolled in Medicare managed care plans. As of November 1, 1996, 98 percent of risk plans offered physicals, 90 percent offered eye exams, 75 percent offered hearing exams, and 38 percent offered foot care. Fifty eight percent of Medicare risk plans currently offer beneficiaries an outpatient prescription drug benefit.

Question. What services does the Administration propose to cover under Medicare managed care?

Answer. As stated above, plans are required to offer all Medicare covered preventive services. The Administration does not require plans to offer specific services beyond the Medicare covered services, however, many plans offer additional preventive benefits.

Question. Mr. Fried, I see that the regional office in Philadelphia took the initiative to have available to Medicare beneficiaries an HMO comparison chart. It is concise and provides important information about the benefits and costs of choosing between traditional Medicare and an HMO. I am informed that the GAO strongly recommended that all of your offices offer such a chart, but that they do not. Shouldn't HCFA be more aggressive in developing and distributing information like this?

Answer. In addition to the comparative information chart developed by HCFA's Philadelphia Regional Office, similar charts have been developed by the Regional Offices in San Francisco, Kansas City, and Atlanta. Also, information about Medicare managed care options is being developed by Medicare Information, Counseling, and Advocacy Programs (ICA's), State Agencies, and consumer groups. HCFA is aggressively developing and distributing clear, accurate, current and consistent managed care information. Among the several initiatives to accomplish that objective is the computerized comparative information project, discussed above.

Question. What measures are you planning to help the consumer make informed decisions on whether joining a Medicare HMO makes sense for them, and if so, which one?

Answer. In addition to the major effort to field comparative managed care plan information, we have embarked on a variety of other initiatives intended to increase beneficiaries' awareness and understanding of Medicare managed care. Our staff has worked diligently to include objective discussions of managed care options in HCFA publications. Several HCFA publications have been re-written and new ones created to address this need. In addition, a re-design of the Medicare "initial enrollment package will provide information about managed care to all beneficiaries at the time of initial eligibility.

We are constantly implementing new initiatives to make more information available to our beneficiary customers; these include a comparison chart, beneficiary satisfaction survey, managed care training module for the ICA programs, and informational materials targeted towards individuals making decisions on behalf of beneficiaries.

Question. Could information that speaks to the HMO's quality and patient satisfaction also be made available?

Answer. In the coming year, HCFA will be conducting the first comprehensive, nationwide survey of Medicare beneficiaries in managed care plans. While the rate of enrollment in managed care plans has increased rapidly, data about beneficiaries' experience in plans has remained minimal. The primary purpose of the survey is to close the gap in knowledge by providing information to beneficiaries that will help them to make more informed health plan choices. Data on satisfaction, access, and quality of care will be gathered from a random sample of beneficiaries in each plan. Results from the survey will be presented in the comparability chart that will also include information on cost and coverage, facilitating both plan-to-plan, and managed care to fee-for-service comparisons.

In addition, in 1997 HCFA will be collecting Medicare relevant HEDIS (Health Employers Data Information set) performance indicators. These quality measures will also be included in the previously described comparison charts.

Question. Would listing the HMOs' disenrollment rates and accreditation status by the National Commission on Quality Assurance be a good guide for the consumer on choosing on the basis of quality as well as costs and benefits?

Answer. Disenrollment rates are not really informative without a context for interpretation. HCFA is currently exploring how disenrollment data can best be used to allow beneficiaries to make a meaningful, informed comparison.

Accreditation by the National Commission on Quality Assurance (NCQA) is another factor that has to be put in context to be relevant to Medicare beneficiaries. Given that all Medicare managed care plans have met HCFA standards, and continue to undergo routine monitoring of Medicare operations, the usefulness of providing information about NCQA accreditation status is unclear and may be confusing. We are working with NCQA and other accrediting organizations to compare standards and their application for the purpose of more focused oversight.

Question. How will your new physician incentive regulations be conveyed to enrollees and to the public?

Answer. The final rule with a public comment period was published in the Federal Register on March 27, 1996. We issued a press release at that time and conducted briefings with many organizations representing consumers, providers and plans. We recently issued a policy letter to all Medicare managed care plans, outlining certain changes to the Physician Incentive regulation which will be announced this month in the Federal Register. A copy of the letter is attached.

The rule requires plans to disclose summary information to beneficiaries about the physician incentive plans upon request. In addition, we plan to publish aggregate information about physician incentive plan data.

Question. Mr. Fried, in what ways will HCFA take a tougher stand to protect Medicare beneficiaries from poor quality HMO's, or is it sufficient to keep the future focus on providing seniors information to help them choose and HMO?

Answer. It is not sufficient to provide data to beneficiaries so they can choose an HMO based on this information. While data will provide some insights that consumers can use to determine how each plan can meet their individual needs, the timeliness of published data is insufficient to reflect each contractor's day to day operations. HCFA will continue to ensure compliance with regulatory requirements enforced through routine monitoring and special investigations. One of the most useful tools for determining effective operations and/or fraud and abuse by plans is through HCFA's review of plan marketing materials, beneficiary complaints, appeals processing and disenrollment activity.

HCFA is currently evaluating monitoring and enforcement activities in order to identify more effective methods of overseeing plan operations. First, HCFA will refocus its data analysis activities to identify specific areas where evaluation is necessary. Second, HCFA will modify its approach so that evaluation activities focus on identified problems and identify root causes for those problems in all HMO operations. Finally, HCFA is devising processes to more effectively conduct investigations. HCFA will dedicate a special team to conduct all investigations to ensure that they are conducted when necessary and that they result in substantial and swift correction of deficiencies.

Question. Mr. Fried, how frequently does HCFA receive complaints about marketing abuses by Medicare HMO's?

Answer. HCFA continues to receive individual complaints about marketing abuses from beneficiaries. Often these complaints focus on the lock-in requirement of the Medicare risk contract. The frequency of complaints about an HMO varies according to the plan's experience and the market. HCFA has noted that more experienced plans operating in markets where beneficiaries are more familiar with managed care tend to register fewer complaints about marketing activities. However, in each case, HCFA staff communicate with the HMO, identify the nature of the problem and resolves the issue on behalf of the beneficiary.

While our approach is to identify and resolve individual complaints about marketing, HCFA also evaluates the frequency and nature of these complaints. Generally, increases in the frequency of marketing and sales complaints is an indication of potential problems with the plan's marketing operations. HCFA requires corrective action plans whenever a Medicare managed care plan's marketing activities indicate that the plan is not in compliance with regulatory requirements. In those cases where the plan is operating under a corrective action plan and fails to correct deficiencies, we will not hesitate to use (impose?) intermediate sanctions until deficiencies are corrected.

Question. Has HCFA taken enforcement actions with regard to plans whose sales agents fraudulently represent the plan or obtain enrollment?

Answer. HCFA has initiated enforcement actions against Medicare managed care plans whenever we identify a greater than expected level of marketing complaints, or a marked increase in complaints. In these instances, HCFA has required corrective action plans that describe the management, resources or processes that the contractor will change to address the identified problem. In addition, we continue to review all marketing and member materials that are provided to beneficiaries to ensure these materials clearly disclose all plan requirements. Finally, periodic onsite reviews provide the opportunity to evaluate all marketing operations, including sales presentations and plan responses to beneficiary complaints about individual sales agents.

Question. Will Medicare HMO plans be required to follow your National Managed Care Marketing Guidelines?

Answer. The provisions in the "Medicare National Marketing Guidelines" represent official HCFA policy and must be followed by all Medicare managed care contractors. Also included in the "Guidelines" are 87 model pieces of correspondence used by contractors to communicate with beneficiaries who are considering enrolling in a plan, as well as those who have already joined the plan. These model letters are not mandatory, however we suggest that the outline of the letters be used by plans to provide beneficiaries with information about coverage, benefits, and enrollment procedures, among other things. Plans have a strong incentive to use these model pieces of correspondence to facilitate HCFA approval of required correspondence items.

Question. Why make these guidelines optional?

Answer. The regulatory authority for Medicare managed care programs, as well as the traditional fee-for-service are of a general nature, with specificity related to certain clinical standards and coverage requirements, as well as payment processes. Often the details of regulatory implementation are left to the provider. For example, HCFA manuals specify what types of information plans must include in marketing materials, as well as the types of material that is prohibited, then leaves decisions about format and additional information to the provider. We then provide guidance to plans on a case-by-case basis. As the Medicare managed care program continues to grow, we have compiled the "Medicare National Marketing Guidelines" as a way to establish some continuity of practice, while allowing plans to remain innovative and responsive to individual market conditions.

Question. Mr. Fried, does HCFA plan to analyze, compare and widely distribute HMO disenrollment rates, as recently recommended by the GAO?

Answer. Disenrollment rate data are used internally for monitoring purposes. A high disenrollment rate, or a sudden surge in a plan's disenrollment may identify

access, education, or quality problems, and will lead to an appropriate investigation. We are in the process of reviewing different methods for analyzing disenrollment rates that may be helpful to consumers. In that case we will make the information available. It is important to take any disenrollment data in context, because disenrollments are often not a result of dissatisfaction. Disenrollments occur for many reasons, including moves out of area or enrollment in another plan with additional benefits of interest to the enrollee.

Question. If so, what have you found?

Answer. Disenrollment rates vary widely across plans and across geographic areas. It is conceivable that individual plan rates could be published as part of a comparison chart. Again, disenrollment rates should not be considered in isolation, because beneficiaries have many reasons for disenrolling. Some recent analyses published by PROPAC and PPRC examined, in aggregate, length of enrollment, switches to fee-for-service vs. to another plan, and disenrollment by profit status of plans.

One encouraging finding is that aggregate disenrollments have been stable at near 20 percent for many years indicating that disenrollments have not risen with program growth. The HCFA Office of Research and Demonstrations is also currently redoing TEFRA HMO studies which will also provide analyses of recent disenrollment data.

Question. Mr. Fried, what is HCFA doing to monitor and provide information on the sickest and frailest members' satisfaction with care?

Answer. The Medicare Consumer Assessments of Health Plans Study (CAHPS) survey contains several questions on health and functional status. These questions will enable us to analyze the responses of those beneficiaries with poorer health and functional status levels and compare them to healthier beneficiaries. The age categories included on the survey will also allow us to take a closer look at the satisfaction levels of the oldest beneficiaries (80 and above), a group that has a higher likelihood of experiencing poor outcomes.

Question. Will enough of these patients be surveyed to make comparisons across plans valid?

Answer. We plan to develop a sophisticated oversampling strategy for future administrations of the survey that we allow us to make plan to plan comparisons of frail elderly and disabled in those plans where the number of enrolled are sufficient to allow us to do so. In developing such a strategy, it is critical to understand that there is no universally accepted definition of frail elderly (that is, there is disagreement about how many, or what specific combination of ADL's or IADL's, conditions, and self-reported health status comprise the best indicator of this population). The HHS Assistant Secretary for Policy and Evaluation is currently funding a study to develop a valid definition of this group to assist in accurate tracking. In the interim, we will pool data across plans based on existing information, to get sufficient numbers to compare the frail elderly and the disabled to healthy beneficiaries to see if their levels of satisfaction differ significantly.

Question. Mr. Fried, are media reports that HCFA is developing a new appeals process true?

Answer. We are not developing a new appeals process, per se, but making significant improvements to the existing process, primarily at the health plan level of review. To summarize the current process: the health plan makes a determination about a service or claim, the plan performs a reconsideration in the event of an adverse determination and the Medicare enrollee requests an appeal, the HCFA independent review contractor performs a reconsideration automatically if the plan upholds its adverse decision. At that point, if the HCFA determination continues to be adverse to the beneficiary and the amount in controversy is more than $100, the Medicare enrollee may pursue the appeal through the ALJ hearing process. Once a dispute reaches the ALJ level of review, the enrollee has available to him/her the full Medicare appeals process used by fee-for-service beneficiaries. The changes we are targeting are at the first and most critical part of this extensive due process—the health plan's appeals process.

Question. Why are you changing the process?

Answer. The current appeals process and time lines for Medicare contracting health plans are based on fee-for-service, as directed by statute and, more specifically, in regulation. Thus, the need for expedited reviews of preservice denials was never explicitly addressed in regulation and the 60-day time lines are now too long and out-of-step with what is possible today. More timely determinations and expedited reviews of adverse determinations are within our authority, and we will ensure that these improvements are done in order to protect beneficiaries.

Question. What exactly are your plans?

Answer. We will be amending current regulations to restructure the time lines in which health plans must make determinations and conduct reconsiderations for all

service or care-related decisions. We will be instituting a regulatory requirement that health plans have an expedited appeals process. Concomitant changes will be made at the HCFA review level. Also through regulation, we will be clarifying the types of health care decisions that are subject to the appeals process to help avoid confusion on the part of health plans and beneficiaries. Lastly, we are developing specifications for a new health plan reporting requirement in order to obtain information on reconsiderations performed at the plan level.

ATTACHMENT 1

CHANGES IN PHYSICIAN INCENTIVE PLAN REGULATION

INTRODUCTION

This communication provides an update on the requirements of the HCFA regulation on Physician Incentive Plans in Prepaid Health Care Organizations. It is directed to all Medicare and Medicaid managed care organizations, including both risk-based and cost-based plans.

A final rule with comment, establishing requirements with respect to physician incentive plans, was published in the Federal Register on March 27, 1996 (Vol. 61, No. 60, pp. 13430–13450). An additional notice, clarifying the tales by which initial compliance is required, was published on September 3, 1996 (Vol 61, No. 171, pp. 46384–5). This rule requires that Managed Care Organizations (MCO's) with Medicare or Medicaid contracts or agreements must disclose information about physician incentive plans to HCFA or the State Medicaid Agencies. Those MCO's that include compensation arrangements placing physicians or physician groups at substantial financial risk (as defined in the regulation) must also assure provision of adequate stop-loss protection and conduct beneficiary surveys.

The September 3, 1996 notice specifies that the compliance date for all provisions (except the survey of beneficiaries and a requirement to report on certain capitation payments) for existing Medicare and Medicaid managed care organizations, the first renewal (or anniversary) date falling on or after January 1, 1997. We expect all MCO's to comply with these dates to the best of their ability. We will, however, be making some refinements, clarifications, and minor changes in the final rule. A Federal Register publication explaining these changes, as well as responding to comments received on the final rule, is being developed and will be published as soon as possible. The purpose of this Operational Policy Letter (OPL) is to advise Medicare and Medicaid MCO's of the changes that will be made in the regulation.

We believe these changes improve the regulation and, overall, will reduce the burden of compliance. We recognize, however, that making changes this close to the effective date will require MCO's to make special efforts to comply. We will not take enforcement action against a plan that has prepared its disclosure report in accordance with the terms of the March 27, 1996 rule and is complying with the requirements of the regulation. Such MCO's will be given additional time to comply with the changes noted in this OPL. Nor will enforcement measures be taken against a plan, for failure to comply with the terms of the March 21 rule, if the plan is making a good faith effort to comply with the changes set forth in this OPL and the remainder of the original March 27 rule. We envision that MCO's will direct their efforts toward compliance with the regulation, with the revisions noted herein.

Managed care organizations having difficulty or problems coming into compliance with these revised requirements should discuss their circumstances with their principal contact person in HCFA or the State Medicaid Agency as soon as possible.

The next section of this OPL describes changes that we will be making to the final rule. As noted above, these will be published in the Federal Register as soon as possible. Further guidance on procedures for meeting these disclosure requirements and other aspects of the region will be sent separately. Medicare MCO's will also receive separate instructions from the Regional Offices concerning annual renewal notices and evidences of coverage for Medicare contracts.

CHANGES IN PHYSICIAN INCENTIVE PLAN REGULATION

Pooling of patients

Certain provisions in the final rule, dealing with the calculation of "substantial financial risk" and with determining the amount of stop-loss insurance, vary according to the size of the patient panel involved. The March rule allowed MCO's to pool patient populations, in certain limited situations, in determining the applicability of these provisions. On further review, we have concluded that changes in these pooling rules are warranted. The changes will make the regulation more consistent with

current practice and with the concerns about financial incentives influencing clinical decisions by physicians that gave rise to the statute. These changes do two things: one, they shift the focus from the managed care plan per se to the physician group with which the plan is contracting; and, two, they allow for more pooling across patient populations, thereby decreasing the burden of the regulation to some degree.

Determination of substantial financial risk.—The final rule specified that a plan's physician group is not at risk, irrespective of its compensation arrangements, if the group has more than 25,000 Medicare patients or more than 25,000 Medicaid patients. Pooling across categories of patients was not permitted for this purpose.

We are changing the regulation to allow the physician group to pool Medicare, Medicaid and commercial patients to reach this 25,000 level and obviate the need for stop-loss insurance. The physician group may also pool patients across more than one managed care plan with which it has a contract. Note, however, that for this purpose the physician group can only pool patients for whom it is at risk under its compensation arrangement. If the risk that is placed on the physician group is segmented by patient category, then these categories cannot be pooled.

Determination of amount of stop-loss insurance.—The March final rule allowed two kinds pooling arrangements that reduced the amount of stop-loss insurance purchased per patient: (a) within a physician group, the group can pool the Medicare, Medicaid, and commercial members of a given managed care organization, but cannot pool across managed care organizations; and (b) the managed care organizations can pool across physician groups.

For the reasons noted above, we are changing both of these provisions:

—First, we are allowing the physician groups to pool patients across MCO's in determining the amount of stop-loss insurance required.

—Second, we are eliminating the arrangement which allows a managed care plan to pool across physician groups to reduce the stop-loss requirements.

This makes the rules on pooling the same for both issues—whether the physician is at significant financial risk and, if so, what level of insurance protection is required.

Note that, as set forth above in the discussion of significant financial risk, the physician group can only pool categories of patients for which it is placed at risk. Moreover, it can only pool across patient groups if the terms of the risk imposed on the physician group is comparable for each category. If separate risk pools are established for these patient categories under the terms of the physician group's compensation arrangement, then they cannot be pooled for purposes of this physician incentive rule.

Payment for stop-loss insurance

The March rule specifically held the managed care organization accountable for the cost of any stop-loss insurance required under the rule. We have concluded that we do not need to mandate how the payment for stop-loss insurance is arranged. We recognize that, in current practice, the physician group often purchases stop-loss insurance that encompasses members of more than one HMO. Moreover, the issue of the cost of insurance is one element, among many, in the arrangement between the managed care organization and its physician group or groups. Consequently, we are changing the regulation to require simply that the managed care plan provide us assurance that the proper stop-loss protection is in place.

Stop-loss levels

The March rule set forth specific stop-loss limits for insurance that was purchased on a per-patient basis. These limits (which are also sometimes referred to as "attachment points" or "deductibles") varied, depending on the size of the patient panel and whether pooling of patients was involved. Although there was some ambiguity in the explanation of these limits, the intent of the regulation was that they represented combined limits that covered both professional services and referrals for hospital or other institutional services.

We recognize that many of the stop-loss arrangements currently in place differentiate between these types of services and establish separate limits for professional services and for institutional services. Moreover, some capitation arrangements may only cover professional services or may have quite different compensation arrangements for professional services than for institutional services. We therefore believe we should recognize these distinctions under our regulation. Consequently, we are revising this provision (in section 417.479(g)(2)(ii) of the regulation) to permit MCO's and physician groups to choose either a single, combined limit or separate limits for professional services and institutional services. We have also revised the categorization of patient panel size to increase the number of categories and smooth out the gradation of attachment points. Based on actuarial analyses and consultation with

experts knowledgeable about current stop-loss insurance practices, we have revised these limits as indicated in the following table:

[Amounts in dollars]

Panel size	Single combined limit	Separate institutional limit	Separate professional limit
1–1000	6,000	[1] 10,000	[1] 3,000
1,001–5,000	30,000	40,000	10,000
5,001–8,000	40,000	60,000	15,000
8,001–10,000	75,000	100,000	20,000
10,001–25,000	150,000	200,000	25,000
Greater than 25,000	....	....	....

Note: Regarding small patient panels: The footnotes in this table indicate that, in these situations, stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but the protections for patient would likely not be adequate for panels of fewer then 500 patients. MCO's and physician groups clearly should not be putting physicians at financial risk for panel sizes this small. It is our understanding that doing so is not common. For completeness, however, we do show what the limits would be in these circumstances.

The timing of disclosure.

General Requirements.—The March rule stated that disclosure of the items specified in paragraph (h)(1) of section 417.479 must be made at the time of application for a contract or a service area expansion or within 30 days of a request by HCFA. The September 3, 1996 notice clarified the initial compliance dates for these disclosure requirements, specifying that MCO's must disclose items (h)(1)(i) through (h)(1)(v) upon the effective date of their contract or contract renewal (or anniversary) date falling on or after January 1, 1997 or the effective date of a new contract or agreement on or after January 1, 1997. (Items (h)(1)(vi), dealing with the report on capitation payments, and (h)(1)(vii), dealing with the beneficiary survey, are discussed below). The upcoming Federal Register publication will establish, as a compliance date for future contracts, that all applicants for new Medicare or Medicaid contracts or agreements must provide the information required under items (h)(1)(i) through (h)(1)(v) prior to the approval of their application. Applicants are encouraged to submit the information with their initial application materials. An application will not be set aside as an incomplete application if it does not contain this information; we will not, however, give final approval of the application, and will not set an elective date for a new contract, without it.

To summarize, the following are the items in section 417.479(h) that MCO's with current Medicare or Medicaid contracts or agreements are required to disclose upon the next renewal or anniversary date:

(h)(i) Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the plan, disclosure of other aspects of the plan need not be made.

(h)(ii) The type of incentive arrangement; for example, withhold, bonus, capitation.

(h)(iii) If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

(h)(iv) Proof that the physician or physician group has adequate stop-loss protection, including specification of the amount and type of stop-loss protection.

(h)(v) The panel size and, if patients are pooled according to either or both of the following permitted methods, the method used:

(A) Including commercial, Medicare, and/or Medicaid patients in the calculation of the panel size.

(B) Pooling together (by the physician groups that contracts with more than one HMO, CMP, health insuring organization (HIO) or prepaid health plan (PHP)), the patients of each of those HMO's, CMP's, HIO's and PHP's.

Important note regarding focus of disclosure: Apparently, some readers of our March regulation have not clearly understood that the arrangements for which we are requiring disclosure are those directly involving the physician. In situations in which there may be two or more tiers of contracting or agreements between the managed care plan and the individual physicians, some readers understood that we were only concerned with the "top tier"—that is the arrangement between the managed care plan and its immediate contractor. This is not what the regulation requires.

The purpose of the statute and regulation is to protect patients against improper clinical decisions made under the influence of strong financial incentives. Therefore,

it is the financial arrangement under which the physician is operating that is of interest and potential concern. Consequently, MCO's must report on the "bottom tier"—that is, the arrangement under which the physician is operating. The reporting requirement is imposed on the plan because that is the entity with which we have a contractual relationship and the entity which is ultimately responsible, under the statute, for making sure that adequate safeguards are in place. We recognize that MCO's may not currently have information on the bottom tier readily in hand and that obtaining it will, in some cases, be a considerable undertaking. We believe, however, that the purpose of the statute is unequivocal and clearly requires the information set forth in the regulation.

Reporting on capitation payments.—The March rule requires that HMO's must disclose detailed information on capitation payments to primary care physicians, broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider services. It requires the managed care organization to report this information at the same time as the other disclosure requirements noted above. However, this timing does not appear to be logical with respect to the operations of a managed care plan nor consistent with our intent on when we desire to receive this information.

The September 3 notice indicated that we were revising this to set a date certain—April 1, 1997—for the initial disclosure of this information. Our upcoming Federal Register document will make this a routine requirement. The report will be due on April 1 of each year, covering payments for the previous calendar year. Again, for managed care organizations with contracts or agreements in effect during calendar 1996, the first reporting date is April 1, 1997.

The timing and nature of beneficiary surveys

The March rule requires that, if there is an incentive plan in place that puts physicians at substantial financial risk, the managed care organization most conduct a survey of its enrollees and recent disenrollees, to determine their level of satisfaction with the quality and access of care provided. The rule requires the survey be administered within 1 year after the date of an incentive arrangement, and every 2 years afterwards.

We recognize that a managed care organization may have several different incentive plans with physician groups, with varying effective dates. This could lead to some confusion about the required timing of these surveys. Moreover, we recently announced that all Medicare HMO's and CMP's will be required to do an annual beneficiary satisfaction survey as a part of our monitoring of the quality of care finished by these organizations. We want to consolidate and simplify these survey requirements. Consequently, we are changing the requirement of this physician incentive plan regulation to make it an annual requirement, with the timing left to the discretion of the managed care are organization, and explaining how it can be combined with the beneficiary survey required under our quality of care initiative.

All Medicare managed care organizations that currently have physician compensation arrangements that place physicians at substantial financial risk will be required to undertake an enrollee and disenrollee survey during calendar 1997. Beginning January 1, 1997, we are planning to require all Medicare HMO's and CMP's, as a condition of their contract with HCFA, to use the survey instrument developed under the auspices of the Agency for Heath Care Policy and Research as part of the Consumer Assessment of Health Plans Study (CAHPS). Beginning in calendar year 1998, the CAHPS survey would fully satisfy the requirements of the physician incentive plan regulation. For calendar year 1997, however, the CAHPS survey falls short of complete compliance with the physician incentive plan regulation in two respects: First, under the quality initiative, CAHPS is not required during calendar year 1997 for MCO's that did not have a Medicare contract in place on or before January 1, 1996. Thus, MCO's that received an initial Medicare contract after January 1, 1996 and before January 1, 1997, do not have to comply with CAHPS, but to have to comply with the physician incentive plan regulation requirement for a survey. Second, the current version of CAHPS does not contain a module for surveying disenrollees. At this time, it only covers current enrollees. CAHPS is being modified to incorporate a module for disenrollees, but that will not be available until calendar year 1998. We are developing a standardized survey of disenrollees that we will make available to managed care organizations to self-administer during calendar year 1997.

Those MCO's with Medicaid contracts or agreements will need to administer the surveys within one year after the first renewal date or anniversary date on or after January 1, 1997 or the effective date of a new contract or agreement on or after January 1, 1997. These MCO's will need to disclose the summary of these surveys prior to the subsequent renewal or anniversary date and every year thereafter.

HCFA CONTACTS

MCO's with questions about any of the provisions in this OPL should direct their inquires to the plan manager with whom they normally interact, either in the HCFA regional office or with the Operations and Oversight Team in Baltimore. Others with questions should contact the Office of Managed Care at 410–786–4287. Inquiries will be directed to the appropriate HCFA staff for response.

HMO GAG CLAUSES

Question. Dr. Gaus, what are some of the barriers that patients face in gaining access to specialists when they need it?

Answer. The ongoing transformation of the health care system has led insurers—both managed care and traditional fee-for-service insurers—to adopt policies that restrict direct access to specialists to encourage more appropriate use of specialty services. Many consumers perceive these policies as limiting their timely access to specialists. These policies fall into several categories:

—*Administrative.*—One policy is the use of a "gatekeeper" which requires patients to be evaluated first by their primary care provider before a referral can be made to a specialist. Another type of administrative policy is a requirement that the patient must satisfy predetermined criteria before they can see the specialist for specific conditions. In this circumstance, often the provider must first call a nurse or other plan representative to obtain approval. This may delay the normal sequence of care.

—*Availability of specialists.*—Plans often contract selectively with specialists and it is not unusual for the list of contract physicians to change over time. Both factors can lead to significant patient frustration with securing access to a specialist of their choosing at a time of illness. In addition, some plans may have no contracts with sub-specialists that may be needed for rare procedures or illnesses, and patients fear that access to such subspecialists may be difficult to achieve.

—*Financial.*—Many plans offer patients the option of seeing a specialist outside their network, but the patient often must pay a larger co-payment. There is also a widespread perception that financial incentives to physicians discourage provision of needed services. Even when these incentives are designed to encourage more "appropriate" and "prudent" practice patterns, they are often perceived by many consumers as leading to denial of care.

In addition, significant concerns have been raised that the language in physician contracts with health plans may preclude them from fully discussing with a patient the operation of the plan and the terms of their coverage. Often collectively referred to as "gag clauses", these contract provisions are cited as prohibiting physicians from disclosing the financial incentives in their contracts, precluding discussion of treatment options not covered by the plan or discussing referrals to specialists outside the plan. In addition, some believe that commonly used contract language that gives plans the right to terminate physicians at any time also discourages disclosure, irrespective of other contract provisions.

We do not know the pervasiveness of these barriers or their impact on the cost or quality of care; there are no studies available to inform our understanding of appropriate and timely referrals to specialists. That is why we have established an active research program that has begun to explore these issues.

HMO ENROLLEES SATISFACTION

Question. Dr. Gaus, given that some subgroups in the Medicare populations are "at-risk" for poor quality care in HMO's, can satisfaction surveys be targeted to their special needs?

Answer. Yes. Our Consumer Assessments of Health Plans (CAHPS) Project, which is developing and testing survey questions which can be used to measure consumers' satisfaction with health plans, can be helpful. As part of the CAHPS project, we are developing a Medicare component that includes a number of questions that are of special interest to persons with disabilities or chronic conditions (access to specialists, and coordination and continuity of care). In addition, CAHPS includes items concerning access to new prescriptions, special medical equipment or devices, rehabilitation therapy and home health care.

The CAHPS survey is structured so that a core set of standard items can be administered across populations. In turn, these core items can be supplemented to address issues of particular importance to a subgroup. There is a set of such items

in the CAHPS survey specifically designed to address issues such as chronic illness or disability.

Question. Can the satisfaction information be used to compare individual doctors within HMO's as well as different HMO plans?

Answer. Not yet, but AHCPR is considering extending CAHPS to develop a provider level survey. A number of the current CAHPS survey questions designed to provide assessments of plans are quite applicable to provider level assessment. CAHPS includes numerous questions about consumers' perception of the quality of care they receive from their health care provider. These questions would be the foundation of a provider level survey.

The challenge with the provider level survey is developing a cost effective data collection strategy that will yield reliable, credible results. In order to compare providers, sample sizes within a region would need to be large relative to those required for comparing plans. The costs of surveying increase as the sample sizes increase. To try to make such surveying affordable, AHCPR would need to develop data collection strategies that will yield adequate response rates, while keeping data collection costs low.

Question. Can your Agency's satisfaction survey be used to compare traditional Medicare with Medicare managed care options?

Answer. Yes. Valid comparisons of different types of Medicare options could be made using CAHPS. The CAHPS surveys are being designed to be applicable across care delivery systems. Questions have been worded, tested and refined to assure that they are equally applicable to fee-for-service as well as all forms of managed care.

We are currently developing and testing, in cooperation with HCFA, a Medicare CAHPS questionnaire. It is designed to provide assessments of Medicare managed care plans. In addition, we have been discussing with HCFA the possibility of developing a CAHPS questionnaire for Medicare fee-for-service. There are a number of challenges to data collection for Medicare fee-for-service including respondents' understanding of their Medicare arrangement, and the presence of Medigap insurance.

EMPLOYERS INFORMATION

Question. Dr. Gaus, typically, do large employers provide multiple health plan options to their employees?

Answer. Historically, employers have limited the number of health plan options available to employees. However, large employers have tended to offer more options than smaller firms. In 1987, the National Medical Expenditure Survey found that 77 percent of firms with 10 to 25 employees offered only one plan, while 32 percent of firms with more than 500 employees offered only one plan.

This trend is continuing according to a 1995 survey of mid-size and large employers conducted by KPMG Peat Marwick. The Peat Marwick survey also suggests that firms appear to be increasing the number of health plans options they offer their employees. The survey found that 70 percent of firms with 500 or more employees offered three or more plan options, and 24 percent of firms with 200 to 300 employees offered three or more plan options.

AHCPR recently cosponsored a survey with the Kaiser Family Foundation on the role of quality information in health care. The survey analyzed employees responses to health coverage provided by their employer. While the survey was not restricted to employees in large firms, it did show that 45 percent of employers offer only one health plan; 15 percent offer two plans; and 33 percent offer three or more plans (included in this category is those respondents who did not know the exact number of plans).

Question. What information, if any, do large employers provide to employees about health plan options?

Answer. I understand that a number of companies are implementing benefit communication systems to convey health plan information to employees. For example, a recent article profiled the efforts of the Boeing Company and AT&T to develop reference guides on plan options for their employees and made the following points. Boeing developed a health plan enrollment kit that was described as "easy to use" and which included user friendly charts and a provider directory. Boeing's package was designed to meet the needs of both employees who were interested in basic plan information, and those who wanted more detailed information. AT&T created a health plan reference book that provides information on health plan options in a narrative, understandable format along with detailed charts on health plan options. AT&T employees were described as actively involved in the book design to ensure that the information was structured in a user-friendly format.

At this time, AHCPR is collecting data from our Medical Expenditure Panel Survey (MEPS) to assess the kind of information that employers are providing employees on health plan options. As you may know, Mr. Chairman, MEPS collects detailed information on the health status, health service use and costs, and health insurance coverage of individuals and families in the United States. The Insurance Component of the survey covers employers' use of health insurance. This component will yield detailed data on health insurance plans, associated premiums, and numbers of plans offered by employers as well as information on plan costs, characteristics, and depth of coverage. The Insurance Component will provide a sample of more than 25,000 employers. We anticipate that this data will be publicly available in the Fall of 1998.

DISENROLLMENT RATES

Question. Dr. Gaus, do you see a downside to HCFA publishing Medicare HMO Disenrollment rates?

Answer. Disenrollment rates, in certain circumstances, can provide important information to public and private purchasers as well as individual consumers. For example, the rates alone are most useful for their "sentinel" effect, alerting HCFA or other purchasers that a potential quality problem may exist. But it is important to recognize that these rates, by themselves, are not equivalent to measures of health plan quality. This is because disenrollment may occur for a number of reasons unrelated to the quality of care of a specific health plan. For example, one reason for disenrollment is the so-called "snowbird" phenomenon in which Medicare beneficiaries disenroll from a plan as they move south for the winter and re-enroll when they return in the spring; another reason is when Medicare beneficiaries may join another HMO that has begun to offer a set of additional benefits that better meets their personal needs. As a result, if disenrollment rates alone are disseminated, it would be important to include a clear explanation of their limitations.

Disenrollment rates are much more helpful when they are linked to information on the reasons for disenrollment. This is an area in which AHCPR can be helpful. In establishing our CAHPS program, we recognized the importance of understanding the reasons for health plan disenrollment and our CAHPS grantees are currently developing a questionnaire module that will enable plans or purchasers to capture that information.

Question. Dr. Gaus, in research and surveys supported by your Agency, what factors lead to individuals disenrolling from their health plans? Have you looked specifically at the Medicare population? If so, what have you found?

Answer. The reasons for disenrollment vary and, as I noted above, they are not always related to issues of satisfaction with the plan or the quality of care provided by the plan. In addition, disenrollment may reflect changes in job status or the offerings of firms to their employees or retirees. While our Agency has not conducted any specific surveys of Medicare beneficiaries, there are several other sources of information.

For example, a 1995 survey by the DHHS Office of Inspector General found that 29 percent of the disenrollees left for administrative reasons, such as moving out of the plan's service area, being enrolled in a plan that terminated its Medicare risk contract, or leaving a company retirement program. Another study by the Group Health Association of America (now the Association of American Health Plans) reported that almost 40 percent who left plans did so for involuntary reasons, such as a change in social security status, change in the plan's service area, failure to pay premiums, or death.

NONDEPARTMENTAL WITNESSES

STATEMENT OF GERALDINE DALLEK, M.P.H., DIRECTOR, HEALTH POLICY, FAMILIES U.S.A. FOUNDATION

Senator SPECTER. Let us turn to panel three. Ms. Geraldine Dallek, director of health policy at the Families U.S.A. Foundation; Mr. William MacBain, representing the American Association of Health Plans; Dr. Robert Margolis, chair of the American Medical Group Association; Dr. John Nelson, Board of Trustees of the American Medical Association; and Dr. Linda Peeno, representing the Patient Access to Specialty Care Coalition.

Thank you all for coming. Let us begin with Ms. Geraldine Dallek, director of the Health Policy at the Families U.S.A. Foundation. Ms. Dallek, the floor is yours.

Ms. DALLEK. Yes; thank you very much. Thank you for having me here today. I think if we have learned anything from the recent election it is that seniors are very nervous about any Medicare changes, yet change is already occurring at an incredibly dizzying speed.

We are seeing a transformation of the way Medicare beneficiaries are paying health care. About one Medicare beneficiary every 30 seconds is enrolling in an HMO.

While managed care, Medicare managed care, holds much promise for Medicare beneficiaries and can and does provide high quality of care, I have seen lots and lots of problems with Medicare HMO's.

My testimony is informed by the 5½ years I was the executive director for the Center for Health Care Rights in Los Angeles which provided education, counseling, and legal assistance to Medicare beneficiaries. The problems I see fall into five areas.

Let me just say I am not opposed to managed care. There are major problems in fee-for-service, but I do think we need to protect managed care enrollees, vulnerable managed care enrollees, the elderly and the chronically ill.

First of all, we continue to see serious problems with marketing abuse in the Medicare program. In numbers of documented instances, HMO marketing agents lie to prospective Medicare enrollees, pressure them to join, enroll individuals who are not able to make an informed enrollment decision, and obtain enrollment signatures under false pretenses.

High rates of disenrollment, I think, are testament to the continuing problems we see with marketing abuse. The GAO released a report this past week, which showed that one HMO in Florida had a 37-percent disenrollment rate and another disenrollment rate in Los Angeles, a 42-percent disenrollment rate. The HMO in Los Angeles was Foundation Health Plan, which previously had problems in northern California. This compares to a 4-percent disenrollment rate in Kaiser.

Second, Medicare HMO's enrollees face a range of access and quality issues, especially access to specialty providers and services such as skilled nursing facility coverage, physical therapy, and home health care.

I want to iterate what was said earlier in the sessions in the panel. We saw and continue to see problems getting home health care services, getting skilled nursing care facility services, physical therapy for chronically ill patients in HMO's.

HMO's would make decisions about physical therapy. We would investigate, sometimes find that they were correct, but oftentimes find that decisions were made in incredibly arbitrary fashion.

I think John Ware's study as well as a recent study by the Colorado-based Center for Health Policy Research, which showed worse health care outcomes for HMO enrollees compared to fee-for-service home health patients should be a wakeup call for both Congress and HCFA to take a look more closely at the kinds of care provided to chronically ill Medicare beneficiaries.

Third, the current Medicare appeals system is broken. It takes months to go through the appeal system. On October 17, 1996, Judge Marquez in the *Grijalva* v. *Shalala* case ruled that, "Procedures followed by HMO's," this is in Medicare, "fail to secure minimum due process for Medicare beneficiaries."

The court also found that, "A more meaningful appeals process by the HMO may actually reduce fiscal burdens on the Federal Government because improper denials of HMO's cause Medicare beneficiaries to return to fee-for-service."

I do know that HCVA will be promulgating—my goodness that was fast—regulations and we certainly hope that they will respond more fully to Judge Marquez's concerns.

PREPARED STATEMENT

The other two issues were data, lack of information, data both for the enrollee as well as in quality of care; and lack of oversight and monitoring. We need to be much more proactive when we see that plans are not providing care, do not follow grievance procedures, or have a significant marketing abuse. I think there is a strong role for both the Federal Government and for Congress, as well as HCFA to do much more oversight in this area.

Thank you.

Senator SPECTER. Thank you very much, Ms. Dallek.

[The statement follows:]

PREPARED STATEMENT OF GERALDINE DALLEK

INTRODUCTION

My name is Geraldine Dallek and I am the Director of Health Policy for Families USA. [1] Prior to coming to Families USA 10 months ago, I was the executive director of the Los Angeles-based Center for Health Care Rights (CHCR).[2] This testimony

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[1] Families USA is a non-profit health care advocacy organization working to improve health care for the entire population, but especially vulnerable populations. Families USA has expertise on a range of managed care consumer protection issues. Its most recent managed care publication, HMO Consumers at Risk, States to the Rescue, reviews recent state HMO consumer protection legislation and regulations (Dallek et al., 1996).

[2] CHCR is an independent non-profit organization dedicated to ensuring that consumers obtain the medical care services to which they are entitled by law. Through funding from its state Health Insurance Counseling and Advocacy Program (HICAP) grant and Los Angeles County

is informed by my experience with Medicare HMO's while at the CHCR and my recent work at Families USA. I appreciate this opportunity to testify on Medicare risk-contract HMO's.

The Medicare program guarantees health security for our nation's seniors. If we have learned anything from the recent election, it is that seniors are very nervous about any Medicare changes. However, change is inevitable as financial pressures in the Medicare program grow. Congress likely will look again at HMO's and managed care as a way to cut program costs. While Medicare managed care holds much promise, it has been beset with a variety of problems that I will be describing today. Thus, as we move in the direction of increased Medicare choice and managed care, Congress must enact strong protections to ensure that Medicare HMO enrollees receive quality health care.

Medicare HMO's are a popular alternative to fee-for-service Medicare. The number of Medicare beneficiaries joining HMO's over the last two years has been nothing short of phenomenal. Although only about 11 percent of the Medicare population is currently enrolled in an HMO, approximately 80,000 beneficiaries a month, or one every 30 seconds, is joining an HMO. During the first nine months of 1996, Medicare HMO enrollment increased by 22 percent (HCFA, 1996). Medicare HMO enrollment is especially dramatic in the western states.[3]

Medicare beneficiaries enroll in HMO's because they offer increased benefits, especially prescription drugs, and significantly reduced out-of-pocket costs. HMO enrollees do not have to purchase a Medicare supplemental policy, the costs of which have been going up dramatically (Dallek, et al., 1996a). Nor do they have to pay the Medicare Part A and B deductibles and co-insurance.

HMO's serving the Medicare population can and do provide high quality care to many enrollees. The exponential growth of these plans is a testament to the good care they provide. However, the experiences of CHCR's Health Insurance Counseling and Advocacy Program (HICAP) and other Medicare advocacy organizations reflect very serious problems in the risk-contracting program that must be addressed. These fall into five areas: Marketing/Enrollment/Disenrollment; Access and Quality; Due Process Protections; Lack of Information; and Oversight and Monitoring.

MARKETING/ENROLLMENT/DISENROLLMENT

Groups representing Medicare enrollees have documented a range of problems with HMO marketing and the enrollment/disenrollment process, including: Poorly trained marketing agents; Inappropriate financial incentives inherent in the commission-based compensation of marketing agents; Marketing fraud/abuse resulting from these first two problems; HMO delays in disenrolling Medicare members on request; and Problems with HMO marketing materials including lack of marketing materials in an enrollee's primary language.

Marketing/Enrollment

Several reports have found serious marketing abuse in the Medicare program. In a number of documented instances, HMO employees have lied to prospective Medicare enrollees, pressured them to join, enrolled individuals who were unable to make an informed enrollment decision and obtained enrollment signatures under false pretenses. (GAO, 1993; Dallek et. al., 1993; GAO, 1996). As recently as July, 1996, The Washington Business Journal (1996) reported that Optimum Choice, a subsidiary of Mid-Atlantic Medical Services, a Medicare HMO, forged beneficiary signatures and violated other Medicare enrollment and disenrollment rules.

Many HMO's pay their marketing agents a commission for each new Medicare enrollee. This compensation system coupled with inadequate training and oversight of marketing agents is a recipe for disaster. For example, in the late 1980's and early 1990's, Los Angeles County Medicare beneficiaries were subjected to massive marketing fraud by one HMO (Dallek, et al, 1993). Although HCFA was slow to react to this problem, once the agency took strong action, the HMO changed its agent compensation system and significantly increased agent training and oversight (see discussion below). Today, Medicare HMO marketing is much improved in Los Angeles County. Nevertheless, misinformed enrollment continues to occur. Moreover, in other parts of the country, Medicare marketing fraud remains a problem. For example, in October 1996 a physician at Cook County Hospital described how a low-in-

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Area Agency on Aging and Federal Insurance Counseling and Advocacy (ICA) grants, CHCR provides education, counseling and legal services to over 15,000 disabled and elderly Medicare beneficiaries in Los Angeles County. Approximately 40 percent of CHCR's work on behalf of Medicare beneficiaries relates to HMO's.

[3] Arizona, 31 percent; California, 36 percent; Colorado, 21.6 percent; Hawaii, 31.1 percent; Nevada, 26.4 percent; and Oregon, 34 percent.

come Medicare patient of his enrolled in an HMO when an agent came to his home uninvited and told him that he would lose his Medicare and Medicaid if he failed to enroll.

Uninformed enrollment has very serious consequences. If beneficiaries continue to seek care in the fee-for-service system, they can face extremely high medical bills as neither Medicare nor the HMO will pay for the care received.

The Case of Mrs. J.—Mrs. J., an elderly Berkeley woman with two previous hip replacement surgeries who does not drive, enrolled in a risk-contract HMO. She believed that she had purchased a Medicare supplemental policy and continued to receive her care from a nearby physicians' group. Medicare subsequently denied her claims. The closest HMO primary care physician was ten miles from her home and inaccessible by public transportation.

Often, marketing can be intense. For example, the summer 1996 edition of Queens Senior reports that HMO telemarketing of seniors in Queens, New York has reached epic proportions:

"One senior gave information about himself to a * * * [HMO] telemarketer and signed the form they sent him. He thought he was still part of traditional Medicare, just that he no longer had to pay Medicare supplemental insurance premiums and a deductible. The senior continued visiting his regular doctor, who is not an [HMO] Medicare member, and he started getting bills. When he asked his doctor why he was receiving these bills, the doctor told him he was no longer on traditional Medicare and would have to pay out of pocket because he had gone out of the network for his doctor visits." (Lee, 1996).

The coordinator of the New York City Insurance and Advocacy (ICA) program describes cases in which seniors attended HMO informational meetings and put their names on what they thought was the sign-up sheet only to find out later they had enrolled in the HMO (Queens Senior, 1996).

High disenrollment rates are one indication of marketing problems. An October 1996 GAO report provides ample evidence that marketing and enrollment problems continue to plague some Medicare HMO plans. GAO compared voluntary disenrollment rates[4] among seven Miami Medicare HMO's and 13 Los Angeles County Medicare HMO's. Disenrollment rates varied dramatically by HMO's. In Miami, PCA had a 1995 disenrollment rate of over 37 percent, and CareFlorida, a rate of 30 percent compared to Health Option's disenrollment rate of 12 percent. Similarly, in Los Angeles, Foundation had a 1995 voluntary disenrollment rate of 42 percent while three additional plans (Prudential, Watts, and Maxicare) had disenrollment rates of over 25 percent. This compares to Kaiser Foundation Health plan's disenrollment rate of four percent (GAO, 1996a).

The GAO also analyzed the percentage of disenrollees who canceled their HMO applications before they were enrolled or disenrolled within three months of enrollment (referred to as "rapid" disenrollments). High rates of canceled applications and rapid disenrollments are a clear indication of misinformed enrollments or marketing fraud. Here again, the GAO found wide variations among HMO's. In Florida, CareFlorida and PCA had combined cancellation rates and rapid disenrollment rates of 30 and 21 percents respectively. Thus, one in three beneficiaries who signed a CareFlorida application and one in five who signed up with PCA either canceled their applications or left the plans within the first three months. This compares to Prudential, where less than 10 percent of new enrollees canceled their enrollment or disenrolled with three months. In Los Angeles, Watts had combined cancellations and rapid disenrollments of 29 percent and Foundation, 20 percent compared to Kaiser with a cancellation and rapid disenrollment rate of five percent (GAO, 1996a).

Disenrollment

Compared to the population enrolled in HMO's through the workplace, Medicare beneficiaries have a much greater opportunity to change health care plans or return to the fee-for-service system. Currently, HMO enrollees can disenroll from an HMO either through a Social Security Office or their HMO. Disenrollment is effective the first day of the month following the month the disenrollment form was received. Thus, a beneficiary who disenrolls from an HMO on July 26 should be back in the Medicare fee-for-service system on August 1.

This procedure presumes, however, that the HMO properly handles the disenrollment request. HICAP cases indicate that some HMO's may not be handling disenrollments in a timely fashion: disenrollment requests are lost or, according to the HMO, never received.

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[4] In addition to voluntary disenrollments, Medicare HMO enrollees may be disenrolled from an HMO because of death, a move out of the HMO's service area, or in rare instances, loss of Medicare eligibility.

HCFA has a system, called retroactive disenrollment, to help enrollees who did not understand or were misinformed about enrollment or whose disenrollment requests are mishandled. Retroactive disenrollment returns the beneficiary to fee-for-service Medicare effective the first day of HMO enrollment, thus voiding the enrollment altogether. But ICA programs report that unless and until the beneficiary learns that they can retroactively disenroll, they become frantic about their unpaid bills, some of which may have gone to a collection agency.

The Case of Mrs. C.—Mrs. C. attended a meeting to learn more about an HMO operating in Ventura County, California. She remembers signing an attendance sheet and nothing more. She says she received more letters inviting her to meetings, but she never went.

In April 1994, Mrs. C. had knee replacement surgery. After the surgery, she received a notice that Medicare denied all claims because she was enrolled in the HMO.

Mrs. C. immediately called the HMO and told them she had never intended to enroll and wanted to be disenrolled. She also requested that the HMO send her a copy of the enrollment form they said she signed. The HMO never responded to this request. With the help of HICAP, Mrs. C. was retroactively disenrolled. In its letter to HCFA requesting retroactive disenrollment, HICAP wrote that "Mrs. C was quite distraught over this turn of events and it appears to be adversely affecting her health."

Unfortunately, some enrollees feel they cannot disenroll because of the high deductibles and co-insurance in Medicare's fee-for-service system. Most HMO enrollees give up their supplemental coverage when they enroll in an HMO. Upon disenrollment, they may find that only the AARP—sponsored Prudential plan will sell them a supplemental policy. However, Prudential may impose a three month wait for coverage of pre-existing conditions. This is a serious problem for beneficiaries who disenroll because they are ill and believe the HMO is not providing them adequate care.

Despite problems associated with disenrollment, the ability to obtain retroactive disenrollment in cases of improper marketing or ill-informed enrollment, and to obtain regular disenrollment the month following the request to disenroll are critical protections for Medicare HMO enrollees.

HMO Marketing Materials

As discussed more fully below, to make an informed decision on whether to join an HMO and which one to join, Medicare beneficiaries need comparative information on benefits and quality. Unfortunately, easy to read comparative information is currently not available. Instead, in a number of markets, such as Los Angeles and Miami, Medicare beneficiaries are bombarded with HMO radio, print, and television advertisements as well as unsolicited HMO mailings. HMO's also provide Medicare beneficiaries on request with HMO informational brochures detailing benefits and other services provided. None of this information allows for easy comparisons of HMO materials, including a comparison of HMO benefits (GAO, 1996a).

HMO advertisements may also be misleading. In Los Angeles, for example, HMO advertisements tend to imply that HMO's are for healthy beneficiaries by generally picturing seniors walking along the ocean or on some scenic mountain trail. Disabled Medicare beneficiaries are not shown in HMO marketing materials, nor do they attend the HMOs' free breakfast and lunch marketing sessions, a major venue for recruitment. Whether for marketing or other reasons, studies have shown that, in general, Medicare HMO's do attract healthier beneficiaries (Riley et al., 1996).

Marketing materials, all of which must be approved by HCFA regional offices, may also result in confusion. For example, a recent advertisement in a major Tennessee newspaper by Health 1–2–3 Platinum, a Medicare HMO, does not mention that the plan is an HMO. Moreover, a footnote on the advertisement explaining that prescription drug coverage will cost extra is almost impossible to read as the type is so small.

The elderly, the poor, and monolingual Medicare beneficiaries are especially vulnerable to inappropriate marketing. On November 4, 1996 the New York-based Medicare Rights Center updated an earlier survey by calling 17 New York Medicare HMO's to assess their ability to provide information in Spanish. Of the 17 HMO's called, 14 had no literature in Spanish, 16 had no Spanish application forms and four had no Spanish-speaking customer service representatives available. In many of the plans with Spanish speaking interpreters, access is limited. For example, HIP of Greater New York requires a scheduled appointment to speak with a Spanish-speaking representative and at Blue Cross, only one out of 30 customer service representatives speaks Spanish (Medicare Rights Center, 1996). Without materials in Spanish and adequate access to Spanish-speaking customer service representatives,

Spanish-speaking Medicare beneficiaries in New York are unable to make an informed decision on whether to join an HMO.

Recommendations

HCFA's response to documented problems with HMO marketing has always been, and continues to be, very slow. From the summer of 1989 to December 1991, HCFA documented serious marketing violations by FHP, a large Los Angeles Medicare HMO. Finally, after numerous complaints by consumer advocacy organizations, and a series of HCFA negative audits and FHP "corrective action plans," promising to fix the marketing problems, HCFA took action. HCFA prohibited FHP from expanding to new service areas for six months until it instituted reforms in its marketing department. However, the plan did continue to market in existing plan areas (Dallek et al., 1993). HCFA's long overdue actions resulted in a change in marketing at FHP. The plan addressed its marketing problems. However, it took HCFA two and a half years to obtain this result. In addition, although the plan had enrolled thousands of Medicare beneficiaries improperly, HCFA failed to impose any serious penalty.

According to a chronology of events in Miami relating to CareFlorida's marketing, HCFA is no more responsive to marketing problems today than it was in the early part of the decade. Beginning in October 1987 and continuing through 1995, CareFlorida had the highest or next to highest disenrollment rates in the Miami market. In February 1991, HCFA found marketing, enrollment, and quality assurance problems but in July 1992 a follow-up HCFA monitoring visit determined that CareFlorida had failed to correct 1991 deficiencies. Each time HCFA required a new corrective action plan. In June 1996, HCFA found that CareFlorida had still not corrected many of the prior documented deficiencies. HCFA required a new corrective action plan and warned CareFlorida that its June findings might jeopardize its contract or require sanctions (GAO, 1996a).

As the FLIP and CareFlorida cases illustrate, it takes HCFA a long time to respond forcefully to problems found in their own investigations leaving Medicare HMO's to violate Medicare marketing and enrollment rules with impunity.[5]

In January 1997, HCFA plans to implement Medicare HMO marketing guidelines. Families USA and other advocacy organizations applaud this initiative. Moreover, the Health and Human Services' Office of Inspector General and HCFA's Office of Managed Care recently printed a very useful guide to Medicare beneficiaries rights under HMO's, including enrollment and disenrollment rights. These agencies consulted with Medicare advocates from around the country when drafting this guide.

Families USA hopes that HCFA will go further, especially in the area of standardizing HMO marketing materials. We are especially concerned that, according to the GAO (1996a), these guidelines do not require standard formats or terminology.

To ensure that Medicare beneficiaries are adequately protected from misleading or fraudulent marketing Congress should ensure that HCFA:

—Requires a ZERO TOLERANCE policy for documented marketing fraud. HCFA should automatically fine HMO's for all documented cases of marketing fraud and publish the number of fines issued by plan name on a quarterly basis. HMO's that fail to correct systemic marketing problems within a six month period should be terminated from the Medicare program;

—Requires all Medicare HMO marketing agents to pass a HCFA-designed training program and written examination;

—Requires HMO's to provide standardized easy-to-read, information at all marketing presentations describing the rules of HMO enrollment, including "lock-in" and requirements for referrals to specialty care;

—Requires (as recommended by the GAO) standard formats and terminology on key aspects of HMO operations in HMO informational materials;

—Prohibits the payment of commissions to HMO marketing agents if a new enrollee disenrolls within three months of enrollment;

—Requires HMO's to independently verify individual Medicare HMO enrollments within three days of each enrollment;

—Requires revocation of a marketing agent's license the second time a financial penalty is imposed for improper marketing;

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[5] In 1995, Foundation Health Corporation did halt enrollment of new Medicare enrollees in California following a HCFA monitoring report which indicated serious problems with its quality assurance plan, its data collection system, and Medicare appeal's system. However, the action was taken voluntarily, not at HCFA's request (Philp, 1995, HCFA Region IX, 1995). Moreover, in 1995, Foundation's Los Angeles Disenrollment rate was significantly higher than that of other Medicare HMO's (GAO, 1996a).

—Requires Medicare HMO's to update their provider list (including specialty providers, nursing homes and home health agencies) monthly and to distribute this list to all prospective enrollees;
—Requires HMO's to develop marketing materials in the primary language of the enrollee when a specified minimum percentage of the Medicare population in the service area speaks a primary language other than English; and
—Prohibits HMO telemarketing to Medicare beneficiaries.

Congress should: Prohibit HMO's from enrolling beneficiaries, instead using HCFA or a subcontracting agency as enrollment brokers; and set standards for organizations that market a particular HMO to their members and ensure that consumers are adequately protected from abuses.

ACCESS AND QUALITY

Risk-contract HMO's operate differently from fee-for-service (FFS) medicine. The structure of these two health delivery systems create different financial incentives. In the Medicare FFS system, the incentive is to provide a high number of services, some of which may be unnecessary and harmful. The more care given and procedures done, the more money made.

The opposite financial incentives—to provide less care—operate in the HMO system. A system that puts providers at financial risk for expensive medical treatment inherently contains incentives to deny or delay needed care (GAO, 1989). We know little about the relationship of financial risk (who is at risk, for how much, and for what services) and patient care outcome in HMO's. However, we do know the types of problems with which Medicare beneficiaries contact Medicare advocacy groups. These access and quality of care problems fall into three distinct areas: Inadequate access to providers, especially specialty providers; delays in obtaining specialty referrals; and denials by HMO's and/or their contracting medical groups of high cost services and procedures, especially skilled nursing home care, rehabilitation services and home health care.

Access to providers, especially specialty providers

In many HMO markets, Medicare beneficiaries sign up not only with a specific HMO, but also with the HMO's contracting medical group. It is the medical group that often makes the decisions to provide or deny care. Access depends on the capacity of HMO contracting provider groups to serve members who have enrolled in their group. Too few providers, too many enrollees, or lack of geographically accessible primary and specialty providers compromises access to care.

Generally, Medicare HMO enrollees have not faced major problems in finding a primary care physician. However, other access problems have surfaced. First, HMO listings of contracting primary care physicians are sometimes out-of-date. Either the physician's practice is full or he or she no longer contracts with the HMO or the medical group. In these instances, Medicare beneficiaries who join a particular HMO because they hope to obtain care from a specific physician are out of luck.

Second, because some primary care physicians enroll more HMO patients than they can handle, they hire other physicians to handle their case load. Thus, although an HMO enrollee may have enrolled up with Dr. X, he or she is consistently referred to Dr. Y. for care.

A third problem for enrollees occurs when their primary care physician leaves the group or the group no longer contracts with the HMO. HMO's do not give enrollees adequate notice that their provider is no longer available to provide them care. This is especially a problem for elderly and disabled beneficiaries under active treatment by a primary care physician.

Far more serious problems, however, relate to access to specialty providers and services. Often, Medicare beneficiaries not only choose an HMO, but also choose a subcontracting medical group or Independent Practice Association (IPA) from whom they get care. The medical group or IPA may, in turn, only contract with a limited number of specialists, none of whom has expertise in the beneficiary's problems. For example, one major Medicare HMO in Southern California offers members a choice of provider groups in several geographic areas. The group serving the Northridge area of Los Angeles County includes two specialists in endocrinology and in hematology/oncology and only one in neurology, surgery, obstetrics/gynecology, ophthalmology, cardiology, allergy/immunology, gastroenterology, urology, orthopedics and pulmonary diseases. Individuals who enroll in this group and need specialty care have no or a very limited choice of providers from whom to seek services (Mitchell, 1995).

Some specialists may not have expertise in a particular medical condition. For example, if the only neurologist in the group is not familiar with Multiple Sclerosis, an enrollee with this condition may not get the care he/she requires. Often, the med-

ical group refuses to refer the patient to an out-of-plan provider, or even another medical group which contracts with the same HMO.

The following case illustrates this problem.

The Case of Mr. R.—Mr. R. called CHCR when his HMO refused to approve his request for out-of-plan surgery, and Mr. R. was awaiting an answer to his written appeal of the denial. At the time, Mr. R. was considering disenrolling from the HMO.

Mr. R.'s primary care physician had recommended thyroplastic surgery to regain the use of his voice due to a damaged vocal cord. Although the HMO group approved the surgery, it sent him to a surgeon who had never performed the type of surgery needed. The group informed Mr. R. that it had no other in-plan surgeon qualified to perform thyroplasty and refused to refer him outside the group.

After several days of telephone calls with Mr. R's primary care physician and the HMO's member services department, HICAP was able to obtain approval for Mr. R.'s out-of-plan surgery.

To reduce unnecessary care, HMO's and their subcontracting medical groups establish utilization review and referral systems. These referral systems may make it difficult for enrollees to obtain care from non-contracting specialists providers, even when these services are not available in the HMO or subcontracting medical group. Moreover, HMO contracting physician groups and IPA's often will not provide enrollees with referrals to specialty physicians and hospitals which contract with the same HMO but are not members of the particular group or IPA.

The Case of Mr. J.—Mr. J. is a 72-year-old Los Angeles Medicare beneficiary who has diabetes and problems with circulation in his lower limbs due to vein blockage. This resulted in a partial amputation of his foot in November 1994. Because of continuing problems, his primary care physician recommended amputation of his foot and lower leg to just below the knee. He received a second opinion from another physician in the same medical group. No alternative to the amputation was mentioned by either physician.

Upon hearing that a less radical alternative to amputation might be possible, Mr. J. sought the opinion of an out-of-plan physician at the Wound Care Center of a large Los Angeles hospital. The doctor suggested that Mr. J. have vein bypass surgery (revascularization) immediately to save his leg. Although Mr. J.'s medical group did not contract with a hospital that could perform this surgery, another medical group contracting with Mr. J.'s HMO did have a contract. Mr. J. tried to transfer to this second group, but was told he could not transfer until the end of the month, an unacceptable delay given the emergency nature of his condition.

After contacting CHCR (which in turn contacted the California Department of Corporations asking for immediate intervention), the HMO transferred Mr. J. to the second medical group and he obtained the needed surgery within the week. He is currently doing well and remains able to walk.

A third problem relates to access to the highest-quality providers. HMO's may not be contracting with the highest quality hospitals. An investigation by a Wall Street Journal reporter found that New York and Los Angeles HMO's were bypassing hospitals with the lowest mortality rates related to coronary-artery bypass graft surgery to contract with hospitals with higher mortality rates (Anders, 1996). HCFA has entered into special contracts with "centers of excellence" in fee-for-service Medicare to ensure that beneficiaries are referred to the highest quality providers. The same requirements do not exist in Medicare HMO contracting.

Access to skilled nursing home, rehabilitation and home health services

Advocates who represent the interests of elderly and disabled Medicare HMO enrollees report a pattern of HMO denials for appropriate skilled nursing facility, rehabilitation or home health services, sometimes explaining to enrollees or family members that they may be able to obtain these services if they disenroll from the HMO and rejoin the fee-for-service system (Dallek et. al., 1993; Grijalva et al. v. Shalala, 1993). Take the cases of Mr. W. and Mrs. J.

The Case of Mr. W.—Mr. W.'s son called CHCR when his father was given a notice that he was no longer eligible for Medicare-covered skilled nursing home care and the physical therapy provided him following a stroke. Mr. W.'s HMO physician told Mr. W.'s son that the HMO "never provided more than two weeks of skilled nursing home coverage." It was not clear from the written notice given to Mr. W. whether the HMO's subcontracting medical group was retroactively denying coverage for the skilled care already received or informing Mr. W. that additional care would not be provided. Moreover, the notice did not specify why care would not be covered, simply stating that "this determination was based upon our understanding and interpretation of Medicare covered policies and guidelines." The notice failed to meet Medicare's most basic notice requirements.

Following-up for Mr. W., CHCR called the nursing home's physical therapist, who reported that Mr. W. was still "making progress" and had "not plateaued," a requirement for continued Medicare covered physical therapy. HICAP asked the HMO to investigate why its contracting medical group terminated what appeared to be medically necessary care. Within two days, the medical group called Mr. W.'s son informing him that physical therapy was being resumed and that the medical group would pay for the two weeks of skilled care already received. The medical group, which has contracted with several Medicare risk HMO's for a number of years, claims it inadvertently sent the wrong notice to Mr. W.

The Case of Mrs. J.—Mrs. J.'s son contacted the Contra Costa County HICAP regarding his 88-year-old mother's HMO's refusal to pay for skilled nursing care following a stroke. The HMO authorized payment for her first 20 days in the facility from October 5, 1994 to October 24, 1994. The plan sent the patient a letter stating it would no longer pay for her stay beginning October 25, 1994 stating that "the care you are receiving * * * no longer meets Medicare guidelines or [the HMO's] guidelines for skilled nursing facility care." No specific reason for the termination of services was given in the notice, as is required by Medicare.

The nursing home staff informed the beneficiary's son that his mother's condition would continue to meet Medicare's skilled nursing facility (SNF) guidelines because she required daily skilled nursing and rehabilitation services. The son felt he had no choice but to disenroll his mother from the HMO effective November 1, 1994. As expected, Medicare approved payment for her continued SNF stay until her 100 days of benefits were exhausted.

Problems sometimes result from HMO staff ignorance concerning Medicare coverage guidelines. Medicare requires risk-contracting HMO's to provide all Medicare-covered benefits. The capitated rate paid to Medicare risk-contract HMO's is calculated with the assumption that covered benefits will be provided. Nevertheless, Medicare advocacy organizations from across the country report the same types of anecdotal cases indicating that HMO's arbitrarily deny Medicare-covered home health services:

The Case of Dr. L.—Dr. L. is an HMO physician who called a California HICAP because she was unable to obtain approval for physical therapy for one of her Medicare patients. The plan's utilization reviewer claimed that physical therapy was not a Medicare-covered benefit and no amount of argument could convince her otherwise. Dr. L. asked HICAP for a copy of relevant Medicare regulations and guidelines regarding physical therapy and was finally able to get her patient the therapy she ordered.

Groups representing Medicare beneficiaries recognize that decisions on what is and is not appropriate or medically necessary care are often difficult. Medicine is not a black and white proposition. Often, after an investigation of enrollee complaints, Medicare advocacy organizations find that the HMO's or contracting medical group's denial of care is appropriate.

Nevertheless, a cacophony of complaints from home health agencies as well as advocacy groups indicate that HMO's do not provide the same level of needed and appropriate home health services provided to fee-for-service Medicare beneficiaries. The problem of obtaining home health aid services is especially egregious. Medicare provides for coverage of needed home health aid services when a beneficiary has also received skilled home health care. Although HCFA does not require reporting by HMO's of home health utilization, and thus no data is available on the level of home health aid services provided, I am convinced that it is minuscule.

The notices used by HMO's to deny home health aid services indicate that this is an area needing investigation. For example, in one recent notice to a Los Angeles Medicare HMO enrollee, the HMO denied home health aid services with the statement that "Custodial Care is an exclusion of HMO/Medicare benefits." This denial does not address the issue of whether the beneficiary, who was receiving skilled home health care services and who was very incapacitated, was entitled to a home health aid. When contacted about the denial, a home health nurse described the patient's plan as "the HMO from hell."

A number of studies also suggest that Medicare HMO's do not provide the same level of services to chronically ill Medicare beneficiaries compared to fee-for-service Medicare and that this differential makes a difference to patient well-being. A study by Shaughnessy et al. (1994) found that Medicare FFS beneficiaries received more home health care and had more favorable outcomes compared to Medicare HMO enrollees. A 1995 survey by the General Accounting Office found that HMO disenrollees rated their quality of health lower than that of enrollees and reported a much greater decline in health status during their HMO enrollment (OIG, 1995). Finally, Ware et al. (1996) found that the chronically ill elderly in HMO's were twice

as likely as the chronically ill elderly in fee-for-service to report a decline in health status during a four-year study period.

Recommendations

Congress needs to act on a variety of Medicare access and quality issues. In 1996, a number of states enacted far-reaching HMO consumer protection laws regarding continuity of care following contract terminations, travel times to care, guarantees of an adequate number of specialty providers and standards for specialty referrals (Dallek, et al., 1996). Congress should examine what these states have done and consider adopting the best state protections for Medicare HMO enrollees. Congress should also enact legislation to ensure that Medicare beneficiaries are adequately protected against HMO financial incentives to deny needed care. Families USA is preparing a list of the most crucial consumer protections that are needed to protect Medicare beneficiaries. We will be happy to share that with you soon.

Congress should enact Medigap reforms to put Medigap insurers on a level playing field with each other and offer greater choice for Medicare beneficiaries. Specifically, Congress should require:

—Medigap insurers to hold an annual open enrollment period with guaranteed issue to allow Medicare beneficiaries to more easily move from HMO membership back to Medicare fee-for-service. Medigap insurers should be required to offer all or, at a minimum, the three most popular standardized plans during the open enrollment period to all Medicare beneficiaries regardless of pre-existing conditions.

—Medigap insurers to sell policies to disabled Medicare beneficiaries under age 65.

Congress should enact legislation or require HCFA to strengthen their regulations in the following access and quality of care areas:

—Remove barriers to specialty care by requiring HMOs to: make out-of-network referrals if they do not have a network provider with appropriate training and experience, including "centers of excellence"; designate appropriately licensed medical specialists as primary care providers for individuals with life-threatening or disabling and degenerative conditions; have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care; and establish procedures that allow enrollees with life-threatening or disabling and degenerative conditions to request and obtain referrals to a specialist or a nationally-designated or accredited specialty care center;

—Require HMO's to pay for out-of-plan providers (including "centers of excellence") with expertise not available in the HMO's provider network;

—Establish utilization review/referral standards that require HMO's to: base referral and utilization decision on written criteria that meet Medicare rules and that are developed with the participation of practicing physicians in the network; use individuals with appropriate expertise and training to make referral and utilization decisions; and make referral and utilization decisions in a timely fashion (two days generally, but within four hours for emergency situations);

—Require HMO's to establish access, travel and waiting time guidelines appropriate for the Medicare population and modeled after those developed by the New Jersey Commissioner of Health (Dallek, et al., 1996);

—Require HMO's to permit Medicare enrollees under active treatment for a particular condition/illness (e.g., heart disease, cancer, stroke, uncontrolled diabetes) whose HMO primary care or specialty provider no longer contract with the HMO to continue to see that provider for a specified time period not to exceed 120 days as medically necessary;

—Review annually all Medicare risk-contract HMOs' internal coverage guidelines to ensure that they are not more restrictive than Medicare coverage rules;

—Compare information with other state regulatory agencies with HMO oversight responsibility; and

—Fine HMO's which fail to provide appropriate care or fail to monitor their contracting medical groups to ensure that they provide Medicare covered benefits.

THE HMO APPEALS PROCESS

Because Medicare beneficiaries are "locked-in" to their HMO's, their right to appeal a denial of care is crucial. Although Medicare's five step appeals process[6] ap-

[6] Organizational determination, HMO reconsideration, HCFA review (done by HCFA's contractor Network Design Group), Administrative Law Judge, Appeals Council and Federal Court.

pears to be quite extensive, it does not meet HMO enrollees' needs for the following reasons:

—Medicare beneficiaries are often not aware of their appeal rights (OIG, 1995);
—HMO's (or their contracting providers groups) often do not provide Medicare enrollees with a notice when care is denied; nor do they inform enrollees that they have a right to appeal that denial. When notice is provided, it is often inadequate;
—The appeals process is too lengthy (the first two steps of the appeal's process take a minimum of 120 days) and provides no help in emergency situations where delays in care could result in significant harm;
—The first two steps of the appeals process are internal reviews within the HMO—the organization which denied (or refused to pay for) the services in the first place; and
—HMO's often fail to meet Medicare appeal time lines.

When faced with poor quality care, or denial or delays in access to care, the Medicare HMO enrollee's only choices are either to work through the lengthy HMO appeals system or to disenroll.

Coverage of out-of-plan claims / meeting appeal time lines

Medicare risk-contract HMO's must, by law, provide their Medicare enrollees with all of the medical care that would be covered by Medicare in the traditional fee-for-service (FFS) system. This includes paying for out-of-plan care that enrollees receive in emergency situations or when enrollees are out of the HMO's geographic area and need care urgently. This requirement also includes paying for out-of-plan services for Medicare-covered care that the HMO failed or refused to provide.

Medicare HMO enrollees experience serious difficulties in obtaining coverage for out-of-plan emergency and out-of-area urgent services. Medicare advocates continue to find that some plans do not process claims in a timely manner:

The Case of Mr. K.—While traveling in Texas, Mr. K. became ill and was admitted to a Texas hospital for what was later diagnosed as congestive heart failure. The HMO gave approval for the emergency and hospital care received. While still in Texas following discharge, Mr. K. obtained two follow-up visits for the same condition. The HMO denied claims for these visits.

Mr. K. contacted CHCR's HICAP which submitted a reconsideration request with the HMO. Within the 60 days required by Medicare, the HMO responded to the claim, denying coverage. However, the HMO failed to notify HICAP, Mr. K.'s legal representative, as was required. Moreover, although the HMO was automatically required to send the denied claim to National Design Group (NDG, HCFA's contractor responsible for all HMO reconsiderations requiring HCFA review), it failed to do so for five months. Following reconsideration, NDG found in favor of Mr. K.

Inadequate notice of appeal coverage denials and appeal rights

Despite years of experience with Medicare, a number of HMO's in California and/ or their subcontracting medical groups do not meet Medicare requirements for notifying enrollees when a service is denied or terminated. Even when a denial notice is given, it is often inadequate.

Some Medicare HMO's in New York are even failing to provide notices when claims are denied:

The Case of Mrs. F.—Mrs. F., a 92 year-old California Medicare HMO enrollee, entered the hospital for congenital heart failure and other medical problems. She was discharged directly to a skilled nursing facility where she received physical and occupational therapy five days a week. Her unstable medical condition was also monitored by a skilled nurse. For these reasons, Mrs. F. clearly met federal Medicare guidelines for coverage of a skilled nursing facility stay. However, Mrs. F.'s HMO denied Mrs. F. coverage because it claimed that the services she received in the nursing facility did not fit Medicare's definition of "skilled services" and were therefore not covered. Mrs. F. never received a written denial from the HMO explaining her appeal rights, but the MRC appealed on her behalf anyway. After several months of negotiations with the HMO, HCFA, and staff at the nursing facility, MRC received notification the HMO would be required to cover the majority of Mrs. F.'s stay in the nursing facility. But because so much time had elapsed, the final decision came too late to prevent the nursing facility from illegally transferring Mrs. F. out of the nursing home to a county infirmary (Medicare Rights Center, 1996).

Like Mrs. F., many Medicare HMO enrollees are unaware of their appeal rights. The recent Office of Inspector General's survey of HMO enrollees and disenrollees found that two-thirds of disenrollees criticized the lack of information on appeal rights and the effectiveness of HMO care and access to services. (OIG, 1995).

Lack of provisions for expedited review in the appeals process

Perhaps the greatest problem with the appeal system is that it does not generally include a mechanism for expedited, independent review outside the HMO in situations where delays in care could result in serious harm. The only exception is for hospital discharge cases where the HMO enrollee can appeal to the Peer Review Organization (PRO) for review if he or she feels the discharge is premature.

The Case of Mrs. S.—Mrs. S. is a 73-year-old Medicare beneficiary in Los Angeles suffering from chronic pulmonary disease. In December 1993, while visiting her daughter in San Diego, Mrs. S. required emergency hospitalization at a non-HMO hospital that placed her on a ventilator to help her breathe. Her non-HMO attending physician recommended placing her in an acute rehabilitation hospital for aggressive respiratory therapy so that, in time, she could be weaned from the ventilator and return home.

Despite the attending physician's opinion that her condition would prove fatal if she were placed in long-term care facility that could not provide the therapeutic services she required, the HMO refused to approve the transfer and offered instead to move her to a less costly nursing facility that did not offer such services.

The Center for Health Care Rights spent two frustrating days trying to convince the HMO that Mrs. S. needed to be weaned from the ventilator, but the HMO refused to transfer her to the acute rehabilitation facility. Only after CHCR advised the HMO's officers that its attorney would appear in court the following morning to obtain a temporary restraining order did the HMO approve Mrs. S.'s transfer to the appropriate facility.

Although CHCR was able to help Mrs. S. obtain appropriate care, without the program's assistance she might well have been transferred to a nursing home, where she would have remained while her appeal slowly made its way through the system.

Grijalva v. Shalala

The rate of federal Medicare HMO complaints is below that of federal Medicare fee-for-service complaints. HMO industry representatives argue that this is a reflection of a low level of problems. Medicare advocates counter that a low rate of appeals is the result of the cumbersome Medicare appeals process and the failure of HMO's to provide adequate notice to Medicare enrollees when a service is denied or terminated. In a decision issues October 17, 1996, U.S. District Court Judge Alfredo C. Marquez agreed in his ruling on Grijolva v. Shalala (1996).

Judge Marquez found that: HMO notices failed to provide the specific basis for coverage denials; many notices were illegible based on a 12-point type readability criteria; "HMO reconsideration approximates a 'rubber stamp' of the initial denial," having "grave consequences because an HMO denial may mean the enrollees will go without medically necessary services" and that procedures followed by HMO's fail to secure minimum due process for Medicare beneficiaries." [emphasis added] The court also found that a "more meaningful appeal process by the HMO may actually reduce fiscal burdens on the federal government because improper denials by HMO's cause Medicare beneficiaries to return to fee-for-service providers at greater expense to the government."

Judge Marquez found that the Secretary of HHS violates federal law if she fails to require that contracting Medicare HMO's: always give notice for denials of service; provide timely and readable notices; clearly state the reason for denials of care in a manner enabling enrollees to argue their case; and inform enrollees of all appeal rights, including the right to a hearing on reconsideration. The judge also found that hearings must be available upon request for all service denials; and be timely according to the seriousness of the medical conditions, including immediate hearings for acute care service denials.

Recommendations

HCFA is currently drafting proposed appeals regulations. This initiative is welcome. Congress should ensure that at a minimum, new HCFA regulations include the following provisions:

—Timely notice to Medicare beneficiaries for service denials and terminations which are legible and which provide detailed information on the reasons for the denial or termination, how to appeal these decisions, and the right to a hearing;

—Expedited review within the HMO of no more that 48 hours when delays would jeopardize the life or health of a patient or the patient's ability to regain maximum function; and expedited review for adverse decisions in these cases to Network Design Group (HCFA's appeals contractor) or other outside review organization; and

—Detailed guidance to HMO's on the circumstances under which they must provide expedited review and specific requirements on who is authorized to conduct

these reviews and the circumstances which must be considered (including Medicare coverage guidelines) in approving or denying the appeal (see generally Grijulva v. Shalala, 1993; Dallek et al., 1993 and Medicare Rights Center, 1996).

In addition, Congress should ensure that HCFA adopt a ZERO TOLERANCE policy for HMO's and contracting provider groups which fail to meet notice and appeals requirements. This policy should impose:

—Automatic monetary sanctions on HMO's and contracting medical groups when they fail to provide beneficiaries with legally required due process; and

—Automatic HMO financially responsibility for all in-plan and out-of-plan claims if the HMO fails to provide an enrollee with a written denial notice that includes information on how to appeal.

Finally, in order to help Medicare beneficiaries with managed care appeals and other problems, Congress should: Provide adequate funding for ICA's to serve as Ombudsprograms for Medicare beneficiaries in both fee-for-service and managed care.

LACK OF DATA

Basic plan benefit and cost-sharing data

Medicare beneficiaries currently lack even the most basic data to help them make an informed choice of health plans. HCFA currently provides far less information about health plan choices to their beneficiaries than that provided by large government and commercial employers. For example, the California Public Employees' Retirement System (CalPERS) provides a range of HMO comparison information to current and retired state employees, including a list of available plans; detailed benefits; premiums, deductibles and copayments; the results of member satisfaction surveys; and plan performance indicators (GAO, 1996a).

Two of HCFA's nine regional offices, on their own initiative, now provide comparison guides on HMO benefits. These are excellent guides providing basic HMO comparative information on benefits and cost-sharing. However, these guides are not readily available to beneficiaries and are limited to only two regions of the country.

Additionally, Medicare beneficiaries need more information than is currently provided in the guides. For example, almost all Medicare HMO's in California offer a prescription drug benefit. However, knowing the total amount of the benefit is not enough for Medicare beneficiaries to figure out which HMO provides the greatest level of protection for the costs of prescription drugs. One California Medicare advocate lists four basic questions beneficiaries need to know to compare prescription drug benefits: What are the coverage rules and standard terms? What is the basis for benefit calculations; How are cost-sharing calculations and limitations on benefits computed? And what are the rules for prescriptions and refills? It makes a big difference to HMO enrollees whether the formulary is open or closed, whether generic drugs are mandatory, limits on the quantity of drugs that can be ordered at one time, how the costs of drugs are calculated (e.g. list price, average wholesale price, wholesale price, mail order), etc. (Burns, 1996).

Access and quality of care data

Advocates for Medicare enrollees understand that it is difficult to argue from anecdotal stories. Often, however, it is all we have. We don't know if the cases cited here are isolated instances of a health care system which consistently provides appropriate care to Medicare enrollees or whether they are the tip of a very large and very deep iceberg.

To make these judgments we need more data. A 1993 study by the Center for Health Care Rights (Dallek, et.al., 1993) included an analysis of HMO hospital utilization data obtained from California's Peer Review Organization. This analysis found a significant difference in hospitalization rates for specific diagnosis related groups (DRG's)—including a six-fold difference in the rates of heart bypass surgery—among the three largest Medicare risk-contract HMO's in California. Because of questions about the accuracy of the hospital HMO utilization data, CHCR did not reveal the names of the HMO's. Instead, it recommended that HCFA strengthen its enforcement of hospital reporting requirements so we could again analyze the data. To date, this has not been done.

A 1996 Institute of Medicine (IOM) report, Improving the Medicare Market: Adding Choice and Protections (1996), contains a long list of information the IOM panel thought should be available to Medicare beneficiaries (Attachment A). Although, much of this information is currently not available, HCFA could do much more to make some information available today in a user-friendly format. The recent GAO

(1996a) report on disenrollments is a good example of how currently available data could be provided to Medicare beneficiaries.

Recommendations

HCFA is currently working on a range of initiatives to provide information to Medicare beneficiaries. These include plan comparability charts, member satisfaction surveys, HEDIS performance measures; national marketing guidelines; a "Medicare transaction system" to collect and analyze complaints; reporting of appeals by plans; and the publication of a Medicare managed care booklet and a Medicare beneficiary advisory bulletin (GAO, 1996a). HCFA should be applauded for these activities, which will clearly result in a more informed Medicare population.

In addition to these initiatives, Congress should ensure that HCFA:

—Requires HMO's to report utilization data, including data on nursing home days, home health visits and rehabilitation services. Without this data, HCFA can not determine whether HMO's are systematically denying needed services;

—Requires HMO's to provide to HCFA information on their referral process including the number of referrals denied and the reasons for these denials. HCFA should provide this information to Medicare beneficiaries;

—Provides, disenrollment data in an easy-to-read format. Although HCFA has some concerns about the data, it is the only measure we currently have of enrollee satisfaction and possible problems with marketing. Further, HCFA Region IX has for over a year and a half been producing this information; and

—Make available to advocacy organizations information about Medicare HMOs' financial incentive plans, which HMO's will be sending to HCFA beginning January 1997.

HCFA MONITORING AND OVERSIGHT

In the past year HCFA has begun a number of critical initiatives to protect Medicare HMO enrollees. It has also reached out to consumer advocacy groups, funding ICA's when Congress eliminated the program and seeking consumer input in the Agency's efforts to address problems that have no easy solutions. HCFA must build on many of the initiatives begun in 1996 to ensure that Medicare beneficiaries feel that the government will ensure they obtain the care they have been promised. If this is to occur, Congress must ensure that HCFA is more proactive than it has been in the past and address the four issues discussed below.

Congress must ensure that:

Medicare HMO problems are addressed in a timely fashion.—As discussed earlier in this testimony, HCFA has responded slowly to many consumer problems including marketing abuses and the lack of appeals protections.

Adequate oversight of Medicare HMO's is provided.—As discussed earlier in this testimony, and in a number of GAO reports (GAO, 1996b), HCFA's efforts to monitor HMO's do not always lead to improvements in care. Problems found are too often not corrected.

Generic problems are addressed by imposing a zero tolerance policy for certain violations of Medicare law.—HCFA should begin automatically penalizing HMO's whose marketing agents fraudulently enroll Medicare beneficiaries. HMO's must be held accountable for the actions of their marketing departments. A slap on the wrist does not prevent further marketing abuse.

HCFA regional offices interpret and enforce Medicare HMO law in a consistent manner.—HCFA's Region IX has taken the lead in a number of areas to provide HMO information to Medicare beneficiaries and respond to HMO problems in a proactive manner. HCFA should work to ensure that information and positive initiatives undertaken by any one region is standardized across regions.

CONCLUSION

In conclusion, I urge Congress to enact strong HMO consumer protections that will apply to all managed care enrollees, including marketing protections, access and quality standards, due process protections and a standardized data set. We are developing a comprehensive list of consumer protections which we would be happy to share with you as soon as it is completed. As Congress considers legislation to encourage beneficiaries to enroll in managed care plans, these additional protections are essential to ensure that Medicare beneficiaries receive accessible quality care.

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STATEMENT OF WILLIAM MACBAIN, SENIOR VICE PRESIDENT, HEALTH PLANS, NEW YORK, GEISINGER HEALTH PLAN, AMERICAN ASSOCIATION OF HEALTH PLANS

Senator SPECTER. I will now turn to Mr. William MacBain representing the American Association of Health Plans. Welcome, Mr. MacBain. The floor is yours.

Mr. MACBAIN. Thank you, Senator. Mr. Chairman and members of the subcommittee, my name is William MacBain. I am senior vice president with Geisinger Health Plan, and I am testifying today on behalf of the American Association of Health Plans, AAHP.

We represent 1,000 HMO's, PPO's, and similar network health plans. Our member companies are dedicated to a philosophy of health care that puts patients first by providing coordinated, comprehensive care.

Together AAHP member plans provide care for over 100 million Americans. Geisinger Health Plan is part of the Geisinger Health Care system, an integrated system of physicians and hospitals that

serves 31 counties in central and northeastern Pennsylvania. Our service area covers nearly 40 percent of the State, and encompasses over 2.2 million people.

Geisinger Health Plan is a central component of that system. Through the health plan we provide health care coverage to nearly 190,000 people who began our Medicare contract in 1994 and now serve 20,000 Medicare beneficiaries.

I firmly believe that our members receive better care than they would through the old fee-for-service system, and here is why. Our health plan supports the cost of a nurse advice service available 24 hours a day. Members who have questions about symptoms, medication, or other coverage can dial a toll-free number. The lines are answered by specially trained nurses, backed up by computerized protocols and physicians on call.

Over 90 percent of physicians and members rate this service as excellent. The program begun 4 years has increased the rate of annual mammogram among women over age 50 from the fee-for-service rate of 57 percent in 1992 to 78 percent in 1995.

We have increased the percentage of Medicare benefits' members receiving flu shots from 29 percent in 1992 to 85 percent in 1995. A study of nearly 3,000 cases of community-acquired pneumonia and bronchitis among health plan members identified a high rate of successful treatment by primary care physicians, and only one of these patients required hospitalization.

A 4-year study of 600 patients with rheumatoid arthritis showed that an overwhelming majority—I am sorry, an overwhelming majority of whom were GHP members, found that they maintained their health status and had a decrease in stiffness and pain.

The expected result in the fee-for-service system would be a deterioration in health status. A reminder system to encourage diabetic members to receive annual eye examinations as recommended to avoid a common complication of diabetes increased the number from 43 percent in 1974 to 70 percent in 1995.

These kinds of quality improvement programs are a key component for the quality health care we provide. This more than anything else sets us apart from the old style fee-for-service system.

Published studies of quality care dating from 1980 have shown a consistent pattern of high quality of managed care plans. For example, a study in the December 1992 edition of the peer review in The American Journal of Public Health found that elderly HMO heart attack patients had similar mortality and better care than their fee-for-service counterparts.

A recent study by HCFA showed that among elderly patients with cancer, HMO members are more likely than fee-for-service members to have their cancer diagnosed at an early stage.

The 1992 study in The American Journal of Public Health found that low-income prostate cancer patients in HMO's have lower mortalities than their fee-for-service counterparts.

A review of literature in The American Journal of the American Medical Association going back to 1980 found HMO quality of care equal to or superior than fee-for-service in 14 of 17 measures.

I recognize that Dr. Ware's study, recently published, raised some questions, and I would like to point out just a couple of concerns I have about those. The conclusions are based on question-

naires in which participants rated their own health status in several categories including physical function, pain, social function, and general health perceptions.

The findings do not differentiate among these. We do not know whether some people went up in one and down in another, and whether that put them in the category of declining health.

Also, unlike the studies of quality we use at Geisinger to measure the success of our quality improvement efforts, Dr. Ware's study does not include any consideration of health care was actually provided and what measurable clinical outcomes occurred as a result.

My written statement contains a more complete and technical discussion of our concerns. I believe I speak not only for Geisinger, but all of the AAHP members in saying we are committed to providing the highest quality of care to senior citizens and to all our members.

PREPARED STATEMENT

We welcome the scrutiny of the subcommittee and we are proud of our excellent record in serving Medicare beneficiaries. I am pleased to have had this opportunity to testify before you today and welcome your questions.

Senator SPECTER. Thank you, Mr. MacBain. I regret the limitations of time, but you can see the length of our inquiries. Your full statement, all the statements will be made a part of the record.

Mr. MACBAIN. Thank you.

[The statement follows:]

PREPARED STATEMENT OF WILLIAM A. MACBAIN

INTRODUCTION

Mr. Chairman and members of the Subcommittee, my name is William A. MacBain and I am testifying on behalf of the American Association of Health Plans (AAHP). AAHP (formerly GHAA/AMCRA) represents 1,000 HMO's, PPO's, and similar network health plans. AAHP member companies are dedicated to a philosophy of health care that puts the patient first by providing coordinated, comprehensive health care. Together, AAHP member plans provide care for over 100 million Americans nationwide.

I am Senior Vice President of Geisinger Health Plan. Geisinger Health Plan is part of the Geisinger system of health care, which also includes a regional tertiary referral center in Danville, a secondary referral center in Wilkes-Barre, 75 physician practice sites, an alcohol and chemical dependency treatment program with an inpatient facility, a management consulting corporation, and a clinical equipment maintenance service. Geisinger is a growing, diversified, regional, multi-institutional system of health care. Our 31-county service area spans over 40 percent of the state of Pennsylvania with an estimated population of 2.3 million. Geisinger Health Plan serves nearly 190,000 Pennsylvanians, including approximately 20,000 Medicare beneficiaries.

I very much appreciate this opportunity to participate in today's hearing and to share with you AAHP's philosophy of care and how AAHP member plans put this philosophy to work in providing quality health care to senior citizens. AAHP's member plans are providing care that is focused on improving and maintaining the health of patients as well as striving to make comprehensive coverage affordable. Based on our experience, comprehensive health care is best provided by networks of health care professionals who are willing to be accountable for the quality of their services and the satisfaction of their patients.

Stated simply, health plans are organized systems for financing and delivering health care. They provide a vehicle for systematic quality improvement that is not available undr the old-style fee-for-service (FFS) health care system. Health plans

combine a number of interrelated features that foster a comprehensive approach to quality, including:

—selection of a defined, fully-credentialed network of providers who can work together on care and quality issues,

—provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality improvement interventions, and

—clinical and fiscal accountability for the health care of a defined population—allowing population-based data collection, analysis, intervention, and monitoring—and ensuring accountability for performance.

This hearing's topic—safeguarding the health care of senior citizens—is of great importance to us. Health plans have made quality improvement programs a key component of their approach to care across all of the populations they serve. These programs include tracking of performance measures, independent audits by peer review organizations, and action plans to continually improve quality of care—all programs that do not exist in the FFS sector.

Many studies conducted by leading researchers have documented that care provided by HMO's is better than or equal to care provided in other settings. In a systematic literature review of quality of care studies published in 1994 in the Journal of the American Medical Association, University of California at San Francisco professors Robert Miller and Harold Luft found that on 14 of 17 major indicators, network-based care was better than or at least equal to that provided under FFS.

Health plans and other integrated delivery systems are highly regulated. At the federal level, the HMO Act offers federal qualification for HMO's that satisfy a rigorous set of standards including solvency, access, quality, and consumer protection components. All Medicare risk and cost contractors must be federally qualified or meet similar program-specific standards. At the state level, 48 states have enacted HMO laws governing issues such as quality and accessibility of services, member information, financial solvency, utilization review, and grievance procedures.

In addition to federal and state regulation, Geisinger and many of AAHP's members have voluntarily sought accreditation by private organizations such as the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The Health Care Financing Administration also is focusing on quality standards in Medicare HMO's through several initiatives which I will discuss later in this statement.

Today I will address the following issues: enrollment and disenrollment trends in the Medicare contracting program and how those trends reflect Medicare beneficiaries' high level of satisfaction with Medicare HMO's and the quality of care they receive; studies that focus on the quality of care provided in health plans, including the recent study by John Ware published in the Journal of the American Medical Association; regulatory requirements that are designed to ensure high quality care in health plans; and operating standards in health plans and how these standards create incentives for high quality health care treatment in health plans.

ENROLLMENT TRENDS AND THE LINK TO SATISFACTION AND QUALITY

More seniors than ever choosing HMO's

More seniors than ever are choosing the comprehensive coverage offered by health plans. From December 1992 to September 1996, the number of senior citizens who chose Medicare HMO's over Medicare FFS coverage doubled, from 2.3 to 4.6 million. According to the Health Care Financing Administration (HCFA), Medicare HMO enrollment is growing by 80,000 to 90,000 beneficiaries per month, representing annualized growth of 35 percent—up from the 25 percent growth experienced last year. Over the last 2½ years, Geisinger Health Plan has enrolled 20,000 beneficiaries, primarily from rural areas.

Seniors are enrolling in HMO's in increasing numbers due to the comprehensive, affordable health services offered. The majority of Medicare HMO's offer routine physicals, outpatient drugs, eye exams, immunizations, and ear exams—services not covered by FFS Medicare—at little or no additional cost. It is not surprising then that many studies, as I will discuss later in this statement—have found comparable or improved access to care for elderly persons enrolled in HMO's. In addition, half of Medicare risk contractors do not charge a monthly premium. The affordability of Medicare HMO's is especially important at a time when seniors are experiencing double digit increases in the average premium for supplemental Medigap coverage, which is unnecessary for Medicare HMO enrollees.

Low level of disenrollment from Medicare HMO's to FFS

Disenrollment rates are one indicator of the quality of care Medicare beneficiaries are receiving and their level of satisfaction with that care. Medicare beneficiaries enrolled in health plans can disenroll each month, so those dissatisfied with the care they receive from health plans can return to the FFS system almost immediately, usually with access to open enrollment Medigap policies. Studies have shown low levels of disenrollment, indicating that beneficiaries are pleased with the care they receive from health plans.

For example, preliminary results of a September 1996 Mathematica Policy Research study conducted for the Physician Payment Review Commission (PPRC) found that two-thirds of the 3,000 Medicare beneficiary sample group had been continuously enrolled in an HMO and that only 2.8 percent had disenrolled from their health plan and returned to FFS Medicare. Twenty percent of these beneficiaries switched because they moved out of the service area or because their health plan ceased operation, leaving just 2.2 percent who switched for satisfaction reasons.

The findings of the Mathematica study are supported by another study released earlier this year by Gerald Riley of HCFA's Office of Research and Demonstrations, which found that cancer patients in HMO's were no more likely to disenroll than cancer-free patients in HMO's. In fact, patients who developed cancer while in an HMO were less likely to disenroll than cancer-free patients.

ACCESS AND QUALITY OF CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS

At AAHP, we recognize that ensuring access to vulnerable and underserved subpopulations is critical and that access is an issue across the health care delivery system, not just for health plans. While the October 1996 Mathematica survey illustrates Medicare beneficiaries' satisfaction with HMO's, preliminary results from the survey [1] point out that more work is needed to improve access to vulnerable and underserved populations—such as disabled persons and African-Americans—who were more likely to report access problems. The survey did find, however, that the incidence of problems is fairly low for all groups.

With rapid enrollment increases and aging of current enrollees, Medicare HMO's are being challenged to meet the needs of a growing number of persons with chronic conditions such as diabetes, congestive heart failure and degenerative joint failure. The Medicare disabled population is expected to grow from 4.2 million in 1996 to almost 8 million by 2010, according to HCFA. With their emphases on prevention, comprehensive benefits, and coordination of care, HMO's are uniquely positioned to meet this challenge.

Health plans bring a number of advantages to managing the care of these populations, such as coordination across a range of providers and access to community-based and home services. In addition, health plans are able to identify chronic conditions and intervene early. In their book, Managed Care and Chronic Illness, Peter Fox and Teresa Fama point out that, while further work is needed, HMO's have instituted numerous services as they manage members with chronic illness, including: screening mechanisms designed to identify those with chronic conditions, non-emergency transportation services for the disabled, educational programs for members with diabetes, arthritis, and other chronic conditions, home safety programs, and visiting or telephoning programs for homebound members.

Fox and Fama's findings grow out of the RWJ Foundation "Chronic Care Initiatives in HMO's" program that they direct. Through AAHP's nonprofit and educational arm, the Group Health Foundation, AAHP has provided an administrative home and support for this important program.

The flexibility offered by a prepaid financing system encourages the types of innovations that Fox and Fama report. The Health Plan of Nevada, which enrolls 25,000 seniors in Nevada, has developed a walk-in resource center for its Medicare members. The Senior Dimensions Service Center assists members with arranging appointments, explaining benefits, providing health education, and offering other support services, particularly for those with chronic conditions. The Center has its own dedicated staff comprising a social worker, a nurse, member services representatives, and administrative staff. The Center handles 1,000 visits and 3,000 telephone calls per month.

Geisinger Health Plan in 1994 instituted a risk-assessment process to identify Medicare enrollees at high risk of illness. Similarly, FHP, Inc. has implemented a case management program, Quality Continuum, also designed to identify members with high-risk indicators. Both programs identify areas for intervention and establish patient care plans to resolve these areas. Many of the members identified by

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[1] The final survey findings were not available prior to this hearing.

these programs are frail elderly. These programs and others like them have no parallel in the Medicare FFS system.

QUALITY

AAHP response to Ware study

AAHP appreciates the opportunity to review our thoughts on the recent study by John Ware, Ph.D., et al., published in the October 2, 1996 Journal of the American Medical Association. We take great interest in research by Dr. Ware and others that measures quality of care in both HMO and FFS settings. Dr. Ware's study compared physical and mental health outcomes of chronically ill adults, including elderly and poor subgroups, treated in health maintenance organizations and FFS systems. The study concludes that chronically ill patients who were either elderly or poor had worse physical outcomes in HMO's than in FFS systems. Mental health patients' outcomes varied by study site and patient characteristics. The conclusions of this methodologically flawed study are not accurate. AAHP believes that due to flaws in the study's design, the study results do not support the conclusion that chronically ill HMO members receive care that does not compare favorably to FFS care for similar patients.

This study, which looks at data from 1986 to 1990, is at odds with a number of other studies from that period, as well as more recent studies showing that care for the chronically ill elderly and poor patients in HMO's is as good as or better than care in FFS. One explanation for the difference in findings may be that the Ware study focuses only on one measure—patient reports of their functional status.[2] This means that the only outcomes that the study examined were those reported by patients. Reliance on functional status alone, without other indicators such as clinical outcomes, process measures, disease-specific dysfunctions, and mortality differences, may produce results that are unreliable and cannot be generalized.

AAHP has the following additional concerns about the study:

—The study is based on data from 1986 to 1990. The health care industry in general, and the Medicare contracting program in particular, grew significantly during that period. HMO's have evolved and matured since that time, and continue to develop new programs aimed at improving the health of patients. Old data should not be used to draw conclusions about the care patients receive today.

—The study examined differences in health outcomes as they were reported by patients. Relevant differences in outcomes were defined as being two point differences on a scale of 0–100. All of the patients started out quite ill (average score 43), and the differences over time were quite similar—a seven point decline in HMO patients and a five point decline in FFS patients. A difference of this magnitude is not clinically important, especially since functional status measures can be influenced by factors beyond a physician's control, such as ease of walking, lifting and dressing.

—The authors note that 54 percent of patients in HMO's reported some decline in functional status, while only 28 percent in the FFS sector reported a decline. But since the average scores were similar (7 vs. 5 point declines), the declines experienced by HMO patients must have been very small. If the declines were larger, they would have pulled the average down to greater than a two point difference.

—The SF–36, the assessment tool used to measure patients' perceptions of their health status, is widely accepted as a valid indicator of health outcomes for most patients. Researchers have raised questions, however, about the validity of the SF–36 for patients at the "extremes," e.g. those who are very sick. Again, this could mean that researchers using the tool are detecting statistically valid differences in patients that are clinically meaningless—the patients may be equally ill. Ware and colleagues also summarized different responses from the SF–36 into a single response. Although this approach makes analysis more simple, it may mask inconsistencies in the data that would lead to different conclusions.

—The study includes all chronic health conditions—hypertension, myocardial infarction, diabetes and congestive heart failure—in the same analysis. The clinical course for these illnesses is quite different and combining these conditions into a single analysis makes it difficult to draw clinical conclusions from this study. It is possible that statistical differences in health outcomes (which, again, may lack clinical significance) are due only to one of the diseases, not all of

[2] Functional status comprises elements such as patient reports of physical function, pain, social function, and general health perceptions.

them, and that worse scores resulting from deterioration related to one of the health conditions being studied pulled down the average score for all patients. Ware's conclusion would be quite different if HMO's did worse on only one disease but were equivalent to FFS on the other three.

—The study controlled for many potentially interacting factors in patient conditions, including age, some co-morbidity, and poverty. Some factors were not considered, which, particularly for the sub-groups with poorer scores, e.g., the poor and elderly, could be quite relevant. These factors include social support, housing, and non-chronic disease issues such as injury/violence. Patients living in nursing homes, or patients afraid to seek care could have a significantly worse perception of their health.

To place matters in perspective, the same issue of the Journal of the American Medical Association published a study examining the impact of insurance status (managed care vs. traditional FFS) on intensive care unit (ICU) length of stay and mortality. The study was conducted by a group of researchers led by Derek C. Angus of the University of Pittsburgh Medical Center. The study found that managed care patients had a statistically significant lower level of mortality and consumed fewer ICU resources than patients in traditional commercial insurance. The lower resource consumption appears to be attributable primarily to patient-related factors.

The same issue also contains an editorial "Managed Care: A Work in Progress" by George Lundberg and Paul Ellwood. The editorial, which expresses the opinions of both the authors and the Journal of the American Medical Association, concludes that "the new American health system works" and has succeeded in providing affordable, comprehensive, quality care to its insured members. As evidence of this, I would like to mention briefly several studies among many that show how well the elderly and poor are doing in network-based care.

Other studies

The success of health plans in improving quality of care—particularly for seniors—has been documented again and again, as studies show care provided in health plans to be as good as or better than care provided by the FFS sector.

—A study published in the December 1992 edition of the peer-reviewed American Journal of Public Health found that elderly HMO heart attack patients had similar mortality and better care than FFS patients. This study comparing the process[3] and outcome of care for hospitalized HMO and FFS patients age 65 and older with acute myocardial infarction found that HMO patients received better care than, and had similar death rates to, patients in a national FFS sample.

—A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the FFS sector. Breast, cervical, and colon cancers, along with melanomas, were diagnosed significantly earlier in HMO's than under FFS. The study attributed this difference to improved access to preventive care under comprehensive HMO coverage. Improved access also is highlighted in a study by the Centers for Disease Control (CDC) and the National Center for Health Statistics, which showed that women in HMO's are more likely to obtain mammograms, pap smears, and clinical breast exams than those in the FFS sector.

—Preliminary results of the September 1996 Mathematica study conducted for the Physician Payment Review Commission appear to support similar findings of improved access to preventive care in managed care settings compared to FFS settings. Fifty-nine percent of female Medicare beneficiaries enrolled in HMO's had mammograms, compared to 37 percent in the FFS sector. Sixty-six percent of Medicare beneficiaries enrolled in health plans received a flu shot, compared to 57 percent for the FFS sector. Even better, at Geisinger Health Plan, 85 percent of our Medicare enrollees received a flu shot.

—A randomized trial of elderly Medicaid beneficiaries, the results of which were published in March 1994 in the Annals of Internal Medicine, found no differences in access, satisfaction and quality of care between beneficiaries enrolled in HMO's and beneficiaries seeking care in the FFS sector. The study found that HMO patients used fewer services than FFS patients but experienced equal health outcomes.

—A 1991 study published in the Journal of the American Geriatrics Society found that elderly hypertension patients (one of the conditions addressed by the Ware study) in HMO's received care that was equivalent or superior to FFS care.

[3] For instance, diagnostic tests, therapeutic procedures, medications, clinical assessments by physicians and nurses, physical examinations.

Based upon standards of care for treating hypertension in elderly patients developed by a panel of expert physicians, the study illustrated that HMO's were more likely than FFS providers to document medications, record alcohol and smoking histories, provide initial orthostatic blood pressure checks, and refer patients to specialists for ophthalmologic, cardiac and fundoscopic exams.

—A 1992 study published in Cancer found that HMO colorectal cancer patients have similar treatment and survival rates to FFS patients. In a study of 330 colorectal cancer patients diagnosed from 1984 to 1989, researchers at the University of Texas Health Science Center found no differences between HMO and FFS patients for duration of symptoms before diagnosis, training of physician who analyzed the tumor, anatomic location of the tumor, type of primary treatment, stage at final analysis, or survival.

—A 1992 study published in the American Journal of Public Health found that low-income prostate cancer patients in HMO's have significantly lower mortality than their FFS counterparts. The study compared treatment and mortality risk of low income prostate cancer patients in HMO and FFS settings.

—A study of 600 rheumatoid arthritis patients at Geisinger Medical Center over a 4-year period showed maintenance of health status and physical functioning, and a decline in pain and stiffness over time. Ordinarily, we would have expected to see a decline in health status for these patients. The majority of patients in the study were members of our health plan.

Regulatory requirements

Health care networks are subject to a wide variety of state and federal statutes, regulations, and industry guidelines designed to promote high-quality care.

Federal regulation.—The Federal HMO Act and Medicare risk contracting regulations provide comprehensive consumer protection standards.

Federal HMO Act.—The Federal HMO Act of 1973 requires each federally qualified HMO to have a rigorous quality assurance program in which medical professionals conduct regular reviews of the health care delivery process and assess patient outcomes. HMO's must have written procedures for remedial action and implement changes as necessary to maintain high quality. The HMO Act also requires plans to use written guidelines for choosing physicians.

Medicare risk contracting requirements.—HMO's serving as Medicare risk contractors must meet additional standards. The Health Care Financing Administration requires Medicare HMO's to undergo external quality reviews by peer review organizations (PRO's) to ensure that they meet "professionally recognized standards of care." PRO's must track patterns of care and outcomes, monitor written complaints about quality of care, and conduct in-depth site reviews. HCFA monitors compliance with these requirements through review of health plan documents and by conducting on-site visits.

State regulation.—Health plans are highly regulated on the state level. Health plans must meet quality standards established by state health departments, Medicaid agencies, and state employee health plans. In Pennsylvania, HMO's must operate an ongoing quality assurance program, which is subject to periodic external assessment. Each Pennsylvania HMO also must submit an annual report to the State Health Department that includes a copy of its quality assurance report and a description of its grievance resolution system.

Private accreditation.—Today's competitive health care market provides a strong incentive for health plans to provide quality care. Accordingly, besides complying with federal and state requirements, a growing number of health plans are meeting the additional standards established for private-sector accreditation.

Private accreditation organizations.—Many employers—particularly large firms—require all health plans serving their employees to be accredited by organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

To gain accreditation, health care networks must meet standards for quality improvement, physician credentialing, recognition of member rights and responsibilities, preventive health services, utilization management, and maintenance of clinical records. NCQA, the largest accreditation organization for network-based health plans, requires plans to operate a comprehensive quality assurance program to monitor and evaluate the quality and appropriateness of clinical care and member services. Monitoring and evaluation programs must address high-volume and high-risk services, as well as treatment for acute and chronic conditions.

To gain NCQA-accreditation, plans must adopt guidelines to ensure that physicians are providing the most effective and up-to-date treatment. NCQA requires

health plans to have procedures for reviewing and updating their practice guidelines. In addition, NCQA-accredited plans must assess member satisfaction by conducting surveys and by evaluating complaints and requests to change physicians. NCQA requirements are widely regarded as the "gold standard" for health plan accreditation.

Reporting of performance data.—Many public and private purchasers require health care networks to report performance data known as the Health Plan Employer Data and Information Set (HEDIS). NCQA worked with employers, health plans, labor and consumer representatives, and health policy analysts to develop the HEDIS instrument. HEDIS includes measures of quality, access to care and patient satisfaction, membership stability, use of resources, financial soundness, and internal management systems.

This past summer, NCQA issued a draft version of HEDIS 3.0 containing quality measures tailored to the needs of Medicare and Medicaid beneficiaries as well as measures developed for privately insured patients. HEDIS 3.0 contains measures that track how well health plans help sick people get better and indicators to assess how effectively plans address the nation's most pressing health problems, such as cancer, heart disease, smoking and diabetes. HEDIS 3.0 also contains a survey to gauge how consumers perceive the care they receive.

HCFA plans to require Medicare HMO's to begin reporting specific data elements from the HEDIS 3.0 data set on June 30th of next year. Specifically, HCFA will require plans to report the HEDIS 3.0 measures of flu shots, breast cancer screening, beta blocker treatment after a heart attack, eye exams for people with diabetes, follow-up after hospitalization for mental illness, and advising smokers to quit. AAHP worked with both NCQA in providing comments on HEDIS 3.0 and with HCFA in discussing implementation issues. We are pleased that HCFA has indicated its intention to collect similar data elements from the FFS sector and hope that this will provide a basis for comparing choices available to seniors.

In addition to HEDIS 3.0 data requirements, HCFA plans to implement four quality measures developed by the Foundation for Accountability (FACCT), a coalition of private and public purchasers and consumers. The quality measures are aimed at making it easier to evaluate health care plans and providers by establishing a national standard for gauging health care performance. The four measures—depression, diabetes, breast cancer, and asthma—were endorsed by FACCT this past summer and are intended to compare how well medical groups or health plans treat these common medical conditions. HCFA has entered into an agreement with The Rand Corp. to implement the FACCT measures in areas around the country. HCFA plans to evaluate implementation issues over the next year before using the measures to derive "report cards" for purposes of plan accountability in 1998.

HCFA also plans to administer a consumer satisfaction survey for Medicare beneficiaries enrolled in health plans. The survey is being developed by the Agency for Health Care Policy and Research in conjunction with HCFA. Medicare contractors would pay the costs for administration of the survey and HCFA plans to use the results to provide comparative reports to Medicare beneficiaries about the health plans available in their geographic areas. AAHP has supported this initiative and shares HCFA's interest in providing beneficiaries with timely and accurate information on their health plan choices. HCFA expects to make these requirements part of health plan contractors' contractual obligations beginning with the 1997 contract year.

INCENTIVES FOR QUALITY HEALTH CARE TREATMENT

To understand why health care networks are achieving an impressive record, it is necessary to examine their operating standards and how these standards create incentives for quality health care treatment. Health plans have several means of ensuring that their members receive high-quality, state-of-the-art care. These include: coordination of services through the primary care physician, use of clinical practice guidelines, implementation of comprehensive quality improvement programs, and analysis of member satisfaction surveys.

I will review each of these in turn.

Coordination.—Health care networks typically create organized delivery systems in which the patient's primary care physician coordinates the patient's health services, including visits to specialists, all hospital admissions, as well as home and community-based care. Coordination and oversight by the primary care doctor help ensure that patients receive appropriate care in a timely manner. Over time, this model of care fosters strong doctor-patient relationships built on mutual understanding and trust.

Clinical practice guidelines.—Most health care networks use clinical practice guidelines to ensure that their members receive the most effective treatments available. Health plan physicians often play a central role in developing these guidelines, which provide strategies for improved diagnosis and treatment of conditions such as asthma, diabetes, low back pain, ear infections, and cataracts. Health plans also have adopted guidelines for regular use of preventive services such as mammography and Pap tests. For example, at Geisinger, we have our own "guideline teams" working on developing guidelines, including those for breast cancer diagnosis, hypertension, depression, urinary tract infection, chest pain, and a host of other conditions.

As reported in the New England Journal of Medicine (1995), Marsha Gold and colleagues at Mathematica Policy Research conducted a national survey for the PPRC of 108 health plans' practice management strategies and physician payment arrangements. The 1994 survey found that approximately three-quarters of HMO's used written clinical practice guidelines.

Quality improvement programs.—System-wide quality monitoring is central to the operations of HMO's and other network-based plans. These programs include tracking of performance measures, independent audits by peer review organizations, and action plans to continually improve quality of care, particularly in areas identified in the performance measurement process. At Geisinger Health Plan, we have an extensive written quality improvement program, which addresses issues ranging from tracking whether diabetics and those with other chronic conditions have received key tests, to reviewing our process for referring members to specialists, to reviewing use of our 24-hour nurse advisory service. We also undertake outcomes research—for example, on migraine management, asthma, and smoking cessation this year—and formal evaluations of care within the plan.

More generally, the 1995 study by Gold and colleagues reported that 79 percent of group- and staff-model HMO's and 70 percent of network- or IPA-model HMO's required health care outcome studies for treatment of particular conditions, had targeted quality improvement initiatives, and used outcome studies to evaluate success and identify areas for improvement. Studies on asthma, diabetes treatment, and mammography screening were most prevalent.

Member surveys.—And finally, health plans conduct surveys and focus groups to assess member satisfaction. Based on members' input, health care networks modify their operations to meet changing needs. At Geisinger, we significantly increased the primary care providers available in our network in response to plan members' requests. Health plans have adopted member orientation programs, providers' business hours, and health education classes to accommodate member preferences. Fifty-five percent of network- and IPA-model HMO's surveyed by Gold and colleagues adjusted physician payments based on results of patient satisfaction surveys.

These key aspects of health plan operations—coordination of care through the primary care physician, use of clinical practice guidelines, continuous quality monitoring, and responsiveness to patient satisfaction surveys—create a comprehensive system of accountability to patients' changing needs and concerns. The high level of accountability provided by health care networks contrasts dramatically with the lack of accountability under the old style FFS system. Fee-for-service plans simply lack the internal structures and processes necessary to create an accountable system.

SATISFACTION

Medicare HMO's attract a broad mix of enrollees, and those enrollees are satisfied with their care. Earlier in this statement, I discussed the preliminary results of the October 1996 Mathematica study as they pertain to low levels of disenrollment. The study also found that most seniors (87 percent) would recommend their plan to family and friends and that vulnerable subpopulations were just as likely to recommend their plan as other subpopulations. Evidence of satisfaction among Medicare HMO members found in the Mathematica survey is supported by prior studies.

—An American Hospital Association survey released in May 1994 found that Medicare beneficiaries enrolled in HMO's and FFS are equally satisfied with the quality of their care. Medicare HMO enrollees rated HMO's positively by a 14-to-one ratio. In addition, Medicare HMO enrollees reported much higher satisfaction with their out-of-pocket costs than did FFS Medicare beneficiaries.

—Medicare beneficiaries enrolled in Blue Cross and Blue Shield affiliated health plans are more intensely satisfied with their health coverage and medical care than traditional Medicare recipients. By a 3 to 1 margin, members with prior FFS Medicare experience preferred their health plan's approach to care to that taken by traditional Medicare. Nearly all members (91 percent) planned to stay with their health plan in the future, while only 2 percent planned to switch to

another health care plan. The September 1995 survey, performed by American Viewpoint, Inc. and commissioned by the Blue Cross and Blue Shield Association, involved 1,500 enrollees of Blue Cross/Blue Shield Medicare HMO's and a comparable number of seniors enrolled in Medicare FFS.

—The same Blue Cross Blue Shield Association study described above found that HMO enrollees with 12 different chronic illnesses and serious medical conditions including cancer, kidney disease, and pulmonary disease reported being very satisfied compared to those patients not enrolled in an HMO.

The Medicaid population also reports high levels of satisfaction with managed care. A study published this past summer in the Journal of the American Medical Association found that Medicaid recipients in New York City enrolled in network-based health plans reported higher levels of satisfaction and better access to care than those with old-style, FFS coverage. Health plan enrollees were much more likely than FFS enrollees to have a usual source of care, to see the same clinician, and to have shorter appointment and waiting times. On each of 14 satisfaction measures, health plan enrollees were more likely than FFS enrollees to give excellent and very good ratings to their personal medical care.

CONCLUSION

At AAHP and at Geisinger, we take serious interest in studies that evaluate quality of care in health plans and other settings. We welcome the focus of this Subcommittee on safeguarding the quality of health care services provided to Medicare beneficiaries. As the many studies we have reviewed today illustrate, health plans have an excellent track record in providing the highest quality of care to all the populations we serve, including seniors. Geisinger Health Plans and other AAHP members are taking the opportunity every day to improve their delivery systems and the quality of care they provide to senior citizens. This opportunity is enhanced by the organizational structures and operating procedures that our members have in place to promote accountability and continuous improvement.

We want to assure you and the members of this Subcommittee that we are committed to working with you and our member plans to ensure that our philosophy of care is evident in all we do. I am pleased to have had the opportunity to testify before the Subcommittee today and on behalf of AAHP.

STATEMENT OF ROBERT MARGOLIS, M.D., M.P.H., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL GROUP ASSOCIATION

Senator SPECTER. I would like to turn now to Dr. Robert Margolis, chair, of the American Medical Group Association.

Dr. Margolis.

Dr. MARGOLIS. Thank you, Mr. Chairman, for this opportunity before you and the committee today. I am a physician. I have been practicing internal medicine and medical oncology for the last 22 years in California, in Los Angeles. I am here today to discuss, hopefully, more of a solution than an issue as to how we can get to the right answer.

That is the role of the integrated provider organization. I would like to start by saying that health plans do not practice medicine, physicians do.

I will talk as I go through this about the doctor-patient relationship and how the accountability at that point in the relationship is where we can meet our dual vision of improved outcomes and reduce costs.

I am here as the chairman of the American Medical Group Association, and that association represents 300 of the most prestigious and best brains in medical care such as the Mayo Clinic, Cleveland Clinic, Oshner, Scripts, and the like.

I am also here as the chief executive of my medical organization, Health Care Partners Medical Group, and I would like to speak from that frame of reference. Our group is one of the largest groups in California. It has 300 full-time physicians and 2,000 specialty

physicians within the organization, and we manage close to 300,000 patients under both fee-for-service and managed care.

In that 300,000 patients, there are 40,000 Medicare HMO patients, risk patients in which we manage under relationships with other health plans. We also incorporate many IPA networks within our organization.

We have a very extensive experience in managed care. I say this not to be immodest, but to suggest that what is possible in an integrated provider organization is to deal from a position perspective on an equal basis with the health care plan in getting the appropriate accountability for both patient satisfaction, quality of care, outcomes, and cost at the doctor-patient relationship.

The incentives and the things that you talked about with the previous panel members can be established and worked out, the physician relationship, so that you reward physicians not based on withholding necessary care, but on the behaviors that are, again, in alignment with the vision that we want and which I believe the American health care system needs.

That is, to improve the care and health of our society, and so that you can incentivize patients—I am sorry, physicians based on quality of care, outcomes, patient satisfaction, access, and the like, as well as elements of the cost of care that they deliver.

You can balance that in a way where you actually have the physicians aligned with the best incentives of providing the necessary care at the most appropriate cost. When you bring this patient care down to the doctor-patient relationship, the doctor is in the position to be able to do the right thing, the thing that he or she has been trained.

Again, I would like to stress that I believe that the difficulty that we are having in this debate, in this conflict between cost and quality, is a significant issue of assuming that the health plan is actually the one that is empowered to deliver health care.

Indeed, if Congress in its wisdom can help to assure that the accountability and the decisions related to health care are at the doctor-patient relationship through a variety of means to assist in the integration of provider systems through things that are ongoing—such as some of the measures to better define antitrust regulations, through measures such as the provider-sponsored organizations, which have been debated in previous sessions and I believe will be debated in the coming session—then we will be able to empower physicians and their health care teams.

PREPARED STATEMENT

Because it is not just physicians, it is integrated systems and teams in order to do the right thing, to provide good, high-quality care to the members that we serve.

Thank you for this opportunity.

Senator SPECTER. Thank you very much, Dr. Margolis. We will have a chance in the dialog, Q&A, to pursue some of those lines.

[The statement follows:]

PREPARED STATEMENT OF ROBERT MARGOLIS

I am Robert Margolis, M.D., Chair of the American Medical Group Association Board of Directors. I am Managing Partner and CEO of HealthCare Partners Medi-

cal Group in Los Angeles. My medical group is one of the largest providers of Medicare managed care services in the country.

I am board-certified in internal medicine and medical oncology with a medical degree from Duke University. I am happy to be here today and appreciate the opportunity to testify before the committee today.

INTRODUCTION

Your letter inviting me to participate requested that I discuss how quality of health care is being affected by practices of health maintenance organizations, including specific references to incentives and disincentives to health care treatment under HMO's. I would like to begin by saying that AMGA believes that any discussion about managed care must focus on the integrity of the patient-physician encounter.

Patient care, despite all the talk about health plans and traditional insurers, is the responsibility of physicians and other individuals providing care under their supervision. Physicians are professionally accountable for the care their patients receive. HMO's do not deliver health care; doctors do. Insurance companies do not practice medicine; physicians do. Medical decisions are made by physicians in consultation with the patient and other health care providers as appropriate. Because of this, the doctor-patient relationship is critical, and the integrity of this relationship must be preserved.

Federal legislation and regulation must assure that quality of care and accountability for health care services resides with physicians and not with health plans, insurance companies or HMO's.

Medical groups have an excellent record of providing the highest quality of care to patients. AMGA asks that Congress keep in mind that the provision of health care by medical groups must be distinguished from the non-medical business of insurance.

THE AMERICAN MEDICAL GROUP ASSOCIATION

The American Medical Group Association (AMGA) is the nation's premiere organization for high-quality, physician-led medical groups. Formed by the 1996 merger of the American Group Practice Association and the Unified Medical Group Association, AMGA now represents over 250 of the nation's most innovative and prestigious medical groups and more than 40,000 physicians practicing in those groups.

Our membership includes many of the most highly-respected multispecialty medical groups in the country, including the Mayo Clinic, the Cleveland Clinic, Scripps Clinic Medical Group, Permanente Medical Groups, MedPartners-Mullikin, HealthCare Partners and many others. Our membership also includes those groups of single specialty or primary care physicians that are held in the highest regard, as well as, independent practice associations (IPA's). All of AMGA's members are governed and managed by physicians: a factor that we believe is essential to the successful delivery of high-quality, cost-effective health care.

AMGA is dedicated to the advancement of these integrated health care delivery systems, and we are eager to work with the Committee and the nation's leaders to find equitable solutions to increase Americans' access to the highest quality, affordable health care.

THE GROUP PRACTICE ADVANTAGE

The Committee is well aware of the revolutionary changes sweeping health care financing and delivery in the United States. AMGA urges the committee to carefully examine the financing, organizational structure and delivery of health services by integrated, medical group practices. We believe that these systems are playing and will continue to play a distinct and vital role in the American health care system.

Clearly, the increased emphasis on the costs and quality of medical care has created the need for better management and more organization in the delivery of health care services. For many years, integrated, medical group practices have recognized that in delivering health care, cost and quality are inseparable. As a result, these systems have evolved and will continue to evolve into highly-sophisticated systems in which patient care is managed for the best outcomes by emphasizing the value of teamwork—an interdisciplinary approach to patient care that focuses on improving the functional status, quality of life and the health of patients.

In fact, the success of integrated group practices can be attributed in large part to their shared mission and their unique culture. They share a commitment to coordinated health care by providers concerned about prevention, education and management of chronic conditions, as well as the treatment of acute conditions. This commitment has been at the heart of the group practice movement for several dec-

ades. As a result, group practice patients benefit from quality care management fostered by an organized system of delivering care that encourages peer review, cross training, professional development, and constant measurement of outcomes.

We urge this committee to take steps to encourage the development of integrated delivery systems. Barriers to integration must be eliminated.

A COMMITMENT TO QUALITY

Much has been said about quality. The President is considering the appointment of a managed care/quality commission. Congress recently enacted maternity length of stay legislation, which for the first time ever, tells doctors how to treat their patients. And there are indications that this is only the tip of the legislative iceberg, with signs that we shall see, in the 105th Congress, gag-clause legislation, mastectomy length of stay bills, etc. It is a slippery slope and one we hope that the Congress will be reluctant to scale. But AMGA understands the motivation for these and other bills: the quest for quality healthcare.

AMGA would like to remind the Committee of that which you already know: True quality in patient care cannot be mandated by any regulatory body. It can only be realized when health systems are structured in such a way that incentives support doing what is best for the patient.

AMGA's members have long been at the forefront in the quest for quality. For many years, they have realized that quality management and outcomes research must serve as the cornerstones of quality medical care. For our members, outcomes measurement and research provides a scientific basis for patient care management. In fact, the group practice setting is ideal for large-scale outcomes measurement and the application of continuous quality improvement because care tends to be delivered in a comprehensive manner to large and stable populations.

Many AMGA members use their outcomes findings to define the best care management practices and protocols, which can be further developed and tested within the groups. In fact, as organized systems of care, our medical groups have developed complex and technologically advanced information systems that enable them to constantly evaluate practice patterns to make continuous improvements. This work leads to better treatments and outcomes for patients, and as a result, cost savings.

AMGA urges the Committee to recommend that Congress take steps to further develop clinical information systems that support medical decision-making based on scientific data on outcomes. In promoting quality of care, AMGA supports an approach that fosters credible, privately-sponsored outcomes research, relies to the greatest extent possible on private accreditation to monitor quality and compliance with standards; and supports establishing information with which consumers and purchasers can make informed choices.

MANAGED CARE VS. CARE MANAGEMENT

Many of the criticisms leveled at managed care in recent months are neither constructive nor accurate. First, nearly all insurance products available to patients today fall under the genre of managed care. Less than 15 percent of Americans outside of federal entitlement programs have pure indemnity style "carte blanche" medical care. In addition, the explosion of health care costs which typified the 1970's, 1980's, and early 1990's has been stabilized through managed care techniques.

The media hype about physicians being paid to under treat and health plans skimping on care to line the pockets of executives is purely anecdotal. In fact, there is no objective evidence of an overall decline in quality under a managed care system. On the contrary, there is evidence to suggest that, for the most part, the majority of patients in managed care plans are highly satisfied with the quality of care they receive.

In a voluntary initiative to measure and benchmark the quality of care delivered in medical group practice settings, more than a dozen members of the AMGA have created a normative database of patient satisfaction results. The results from this project are being used for monitoring the patient care, external benchmarking and physician quality improvement purposes. The survey instrument being used is designed to assess the patients satisfaction with the accessibility and acceptability of the care provided (Ware and Hayes, 1988; Davies and Ware, 1991). To date, the satisfaction results from more than 42,000 patient visits have been aggregated for analysis. (See Attachment A.)

Although this data has not yet been published, an analysis of the database reveals that patients in managed care plans rate their care as highly as the patients not in managed care. The representation of payment methods in the database includes: Medicaid/Medicare (23.8 percent), HMO/PPO (36 percent), Private Insurance (29.1 percent), and other (11.1 percent).

Recent findings published in the Journal of the American Medical Association conclude that in an 11-year study of patients with rheumatoid arthritis, there was no difference in either the quantity or quality of care received in fee-for-service versus managed care settings. (Journal of the American Medical Association, October 2, 1996, Vol. 276. No. 13, page 1048.) We believe, with few exceptions, this reflects the maturing managed care market as a whole.

Managed care, capitated, or prepaid care creates a unique patient/physician partnership that works toward better total health for individual patients and for the community at large. Its built-in efficiencies and incentives have the potential to reduce costs and, therefore, provide more care for less money. The change from traditional fee-for-service to prepaid health care may seem to be difficult for some who are familiar with the old system—which is warm and comfortable—but inefficient. The fact is, Americans deserve a better health system; one with lower costs, greater choice, and more control over personal health decisions. Managed care gives patients—working in partnership with their physicians—more responsibility for their own health, which most Americans prefer.

Managed care opponents criticize the role of the primary care physician, falling back on the ill-conceived "gatekeeper" term to suggest denial of access to specialists. In reality, the purpose of the primary care physician is to provide a coordinated continuum of care, taking responsibility for the patient's complete care, providing preventive and acute care as needed, and coordinating specialist care. Primary care physicians may be general practitioners, family physicians, internists, pediatricians, or obstetrician/gynecologists—the same trained physicians to whom patients have entrusted their care for years. Primary care physicians refer patients to specialists when needed, just as they always have done. The difference is that their patients do not see a multitude of doctors without their knowledge. This gives one physician complete knowledge of the case and saves the cost of unnecessary specialist care. Again, the focus is on the complete and appropriate care of the patient.

AMGA certainly recognizes that there is a growing public apprehension about managed care. We continue to hear anecdotal evidence that patients are having difficulty receiving the care they need, which in turn fuels the perception that the battle against rising health care costs may have gone too far. We must remember, however, that managed care often means a lot of different things to a lot of different people.

AMGA would like to emphasize that our members define managed care first and foremost as the management of actual patient care or care management in order to provide the most appropriate, high-quality cost-effective care. To AMGA medical groups, managed care can not be defined as simply the management of dollars.

In fact, AMGA represents systems that have adopted a variety of different payment mechanisms, including both fee-for-service and capitation. In fact, the medical group practice mode of delivering health care existed long before the cost containment pressures of the past two decades. A commitment to coordinated health care has been at the heart of the group practice movement for several decades. Even in a fee-for-service context dominated by indemnity style insurance group practices have embraced delivery systems of coordinated providers that manage patient care using a multispecialty model.

Within AMGA, this shared view of the best way to care for patients is the common ground where medical group practices that have operated largely in a fee-for-service context have come together with prepaid medical group practices. Managed care techniques, including utilization review, quality improvement programs, case management, capitated reimbursement of physician groups, reliance on primary care and exclusive networks of carefully selected, integrated providers, have been integral to many medical group practices long before managed care spread because of cost pressures.

RESPONSE TO DR. WARE

AMGA read with great interest the recent studies by Dr. John Ware, Ph.D., and others in measuring the strengths and weaknesses of medical care in various settings. AMGA acknowledges and appreciates the work of these scholars. Dr. Ware's results constitute good news for those who consider HMO's as a solution to rising health care costs. Outcomes were equivalent for the average patient in HMO's as in the FFS plans. However, he cautions policy makers that these results cannot be generalized to high-risk groups and cannot be generalized across study sites. Clearly more work is necessary, and as he states: "health care plans should carefully monitor the health outcomes of these vulnerable subgroups."

Dr. Ware's study began in 1986 and was concluded with follow-up through 1990. The MOS was an observational study of variations in practice styles and of out-

comes for chronically ill adults in Boston, Chicago, and Los Angeles. "Results," he says in the article, "should not be generalized to HMO or FFS plans in other cities or rural areas."

The critical distinction that must be drawn is that outcomes studies yield evidence of variation from site to site. Further investigation may yield important clues regarding processes of care which clearly offer measurable improvements in the health status of patients.

AMGA physicians have found that quality outcomes measurements go a long way towards assuaging the fears of our patients. As John Ware has pointed out, there are populations within our health care system that are vulnerable and need to be followed more carefully. For a number of years, AMGA's medical group practices have been tracking potentially vulnerable groups of patients to assure that sufficient attention is paid to undiagnosed health conditions and prevention.

For example, we have learned that 33 percent of patients with diabetes screen positive for risk of depression. The data also show that those who screen positive for depression have significantly lower average scores on all diabetic functioning scores than patients screening negative for depression (See Attachment B.). Armed with this information, clinicians treating patients with diabetes can direct services toward diagnosing and treating all underlying symptoms in addition to the diabetes itself.

AMGA has been at the forefront of measuring the success of Medicare managed care plans. AMGA believes that as the measurement technology becomes more sophisticated, medical group practices will be able to amply demonstrate to everyone that Medicare managed care plans provide equal or greater medical care.

Dr. Ware has asked the important questions: "What are the 'clinical' correlates of changes in patient assessed functional health and well-being? What can health care plans do to improve outcomes, and what specific treatments have been linked to physical and mental health outcomes as measured by the SF–36 Health Survey?" Dr. Ware enumerates the areas of clinical research where significant correlation has been established between SF–36 scores of disease severity and treatment response. As he states: "Identification of the clinical correlates of changes in physical and mental health status warrants a high priority in outcomes and effectiveness research." It is very important to take note of the final comments of the article: "The contrast between results reported here for high-risk patients versus results reported previously for the average patient underscore the hazard in generalizing about outcomes on the basis of averages. This is why quality improvement initiatives focus on variations rather than only on usual performance. Patient-based assessments of outcomes are likely to add significantly to the evidence used in informing the public and policy makers regarding which health care plans perform best—not just in terms of price, but in overall quality and effectiveness."

MEDICARE MANAGED CARE

AMGA appreciates the opportunity to be heard on the many changes occurring in Medicare managed care. Many of AMGA's medical group practices have Medicare managed care programs. AMGA believes that Medicare managed care provides health care at quality equal to or superior to that of fee-for-service and with the added benefit of less administrative hassle to both the physician and the patient.

Medicare is one of the fastest growing segments of the managed care markets. Competition for Medicare enrollees has increased further with the expansion of the Medicare Select program, and the addition of other new Medicare options. The market is expected to grow even more competitive in the near future if Congress permits providers to go directly at risk for Medicare enrollees as participants in provider-sponsored networks (PSN's). AMGA would like to point out some of the strengths and weaknesses of the Medicare managed care program that our medical group practices see on an almost daily basis.

CHOICE

AMGA's medical groups know that "choice" is probably the single most important consideration for Medicare beneficiaries when thinking about joining an HMO. Many Medicare beneficiaries see HMO's as limiting their freedom of choice. Some Medicare Beneficiaries see joining an HMO as losing control over such things as the selection of their doctor and how long they stay in the hospital.

In order to respond to this, AMGA medical groups are improving their appeal to seniors by developing the broadest possible network of providers. In order to offer enrollees more choice, other Medicare managed care plans have developed product alternatives such as a Point-of-Service (POS) product. This alternative allows members the option of receiving services outside of the HMO's health care network for

specified services in exchange for higher coinsurance, co-payments or deductibles. A POS benefit may make a Medicare risk plan more attractive to those who wish to be treated by an out-of-network provider.

However, managing a POS product presents several challenges to both the medical group and the HMO. To be successful, a medical group must have the capacity to effectively manage the utilization of out-of-network services and associated costs. A plan must be able to track who is going out of the plan's established network, the types of services received and the costs of the POS benefit. And enrollees must be educated about all costs and possible financial risks associated with using a POS benefit. I should add, however, that as networks grow larger, the overall benefits of a POS product may become more one of perception.

And so, the market is driving more health plans to offer POS options. With an investment of time and capital, POS options have been highly successful—even though AMGA's experience is that Medicare HMO beneficiaries rarely utilize their rights to go out of network. Still, AMGA recognizes that this added benefit can be comforting to some beneficiaries with little or no experience in managed care. However, because of the high costs to some medical groups to establish POS options, AMGA would oppose a federal statute, mandating that POS options be required by law. POS options should be a voluntary response to market demands.

Between the growing size and extent of provider networks and the development of POS products, AMGA believes that the markets are responding to the desires of Medicare beneficiaries for more choice in the selection of Medicare managed plans.

COVERAGE

The next factor in analyzing Medicare managed care which AMGA would like to address is the issue of "coverage." Recent studies by AARP and HCFA conclude that Medicare fee-for-service covers only 50 percent of a beneficiary's total health care needs. Therefore, the vast majority of Medicare beneficiaries must purchase some form of coverage to supplement services covered under Part A and Part B.

Even though recent federal laws require the standardization of Medigap policies, many seniors remain confused over the scope of Medicare and supplemental policies. Many of AMGA's medical groups have found that Medicare managed care generally offers seniors with a greater level of coverage than their supplemental policies. Many Medicare managed care plans offer coverage for dental, vision and prescription drugs—three areas which Medicare fee-for-service does not cover.

AMGA's experience has been that as seniors become more aware of the coverage afforded through most HMO's, the attractiveness of an HMO option increases. Still, many seniors continue to worry that HMO's have too great an incentive to withhold needed care to reduce the cost of care. This is a problem that AMGA physicians have attempted to face.

CONVENIENCE

One of the most common concerns that AMGA's medical groups hear from Medicare fee-for-service patients is that they are confused by the Medicare intermediary's paperwork and administrative processes. Thus, Medicare managed care was designed with the intent of reducing considerably the number of forms that must be filled out. AMGA has received considerable, positive feedback that reduced paperwork is a significant convenience and one of the greatest strengths of a Medicare managed care plan.

Patients are also attracted to the Medicare managed care concept because of the idea that they have "one stop shopping." That is, one medical group practice provides all health care services—often in one location. This is another core strength of the program. AMGA is made up of physicians—of many specialties—who practice together, believing that this is the best way to provide care. Our medical group practice philosophy naturally complements the desire of patients to have health care provided—as much as possible—in one location.

COST

AMGA medical group practices see on an almost daily basis that seniors usually live on fixed incomes. For this reason, "cost" is another factor that AMGA would ask the Committee to keep in mind. Medicare managed care can be provided to beneficiaries in such a way that saves beneficiaries' financial resources. According to HCFA, nearly two-thirds of all Medicare managed care plans currently offer a zero premium product. This is a 40 percent increase in the last five years.

But it is interesting that zero-premium plans have sometimes raised concerns among seniors. Many of our medical group practices have found that our physicians must spend considerable time educating beneficiaries who do not understand how

a plan can deliver good health care without charging some kind of premium. This is especially true in areas with little or no experience in managed care.

Payments to Medicare managed care plans should be risk adjusted to take into account the higher costs of treating people with chronic and more expensive health problems. Plans with a demonstrably higher share of beneficiaries with expensive chronic diseases should be paid more. The Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Without better risk adjustment, medical groups with excellent programs for patients with chronic diseases may be reluctant to offer their own Medicare health plans for fear of adverse risk selection.

PROVIDER-SPONSORED ORGANIZATIONS (PSO'S)

AMGA supports legislation which would allow "provider-sponsored organizations" (PSO's) to contract directly with HCFA to deliver medical services to Medicare beneficiaries. Under most legislative proposals, PSO's would be required to offer all Medicare Part A and Part B services for a federally defined monthly payment. Under these proposals, Medicare PSO's would be functionally similar to many state regulated HMO's.

AMGA supports the inclusion of provider-sponsored organizations as a Medicare option. Some organizations have criticized recognition of PSO's, arguing that PSO's should be regulated as HMO's. On the other hand, AMGA believes that these PSO's should meet federal quality and solvency standards but should not be subjected to state licensure as HMO's in order to contract with HCFA. Holding PSO's to the same solvency standards as insurers could create barriers to their entry into the market.

CONCLUSION

In closing, AMGA believes that Medicare patients have unique needs and characteristics. AMGA medical group practices have designed Medicare managed care plans with these needs in mind. The needs of the Medicare population require a coordinated care approach—which multispecialty medical group practices are perfectly situated to deliver.

In short, AMGA believes that Medicare managed care works. Medical group practices have made great strides in improving the satisfaction of our patients. AMGA looks forward to working with Congress in the future and the Association appreciates the opportunity to testify before the Committee.

ATTACHMENT A

AMGA RELEASES SPECIALTY RESULTS FROM RAPIDLY GROWING PATIENT SATISFACTION REGISTRY

Alexandria, VA (October 20, 1996)—According to the results released today from the American Medical Group Association (AMGA) Patient Satisfaction database, patients visiting Pulmonary Medicine physicians are more likely to be satisfied with their overall care than patients visiting any other specialty in the database. The other highest scoring specialties included Orthopedic Surgery, Cardiology, and Pediatrics. AMGA Chief Executive Officer, Donald W. Fisher, Ph.D. states "AMGA members are using these results to monitor the quality of care provided to their patients and provide quality improvement benchmarks to their providers."

After just one year of activity, the members of the American Medical Group Association have successfully created a benchmarking database of patient satisfaction observations. To date, satisfaction scores from nearly 45,000 patient visits to almost one thousand physicians practicing 40 different specialties in 14 medical group practices have been contributed to the national database. To meet the increasing demand for access to this database, AMGA has doubled the number of reporting cycles available to members, added an optional data-entry scanning service and is currently exploring options to make the data available interactively through the World Wide Web. AMGA provides benchmarking reports to each physician in the database at several levels of aggregation. Physicians can compare their results to their own group practice colleagues, all physicians nationally of the same specialty, as well as against the full results of the aggregate database. In addition, physician-specific results are reported over time to provide a baseline for measuring their own improvement against.

Based on projections given by the participating medical groups, AMGA expects the database to exceed 100,000 patient observations by the first quarter of 1997. "The extremely rapid growth of this project illustrates the dedication of group prac-

tices to providing the highest quality of care to their patients," comments Fisher. Vice President of the Quality Management and Research Department, Julie Sanderson-Austin adds, "AMGA members have succeeded in creating a standardized set of satisfaction benchmarks for all others to compare quality improvement initiatives against."

To collect the patient satisfaction data, patients were asked to complete a questionnaire during their clinic visit. The survey contains three questions designed to assess accessibility of care, five pertain to the quality of care delivered, a single question provides an overall visit rating, an assessment of general health and the patients' opinion on recommending the provider to family or friends. Results are reported to physicians in terms of the percentage of their patients who responded "Excellent" to each of the scaled questions.

At the aggregate level, 48.1 percent of the patients reported their overall visit with the provider was "excellent". Results from practice specialties with at least 10 physicians sampled varied from a low of 41.8 percent 'excellent' to a high of 53.34 percent 'excellent'. The rank ordered specialty level results are: Occupational Medicine—41.84 percent; Otolaryngology—43.05 percent; Gastroenterology—43.80 percent; Infectious Diseases—43.80 percent; Dermatology—44.13 percent; Neurosurgery—44.98 percent; Psychiatry—45.63 percent; Internal Medicine—46.25 percent; Family Practice—47.12 percent; Ophthalmology—47.88 percent; Urology—48.13 percent; Allergy/Immunology—48.26 percent; Obstetrics/Gynecology—48.74 percent; General Surgery—49.18 percent; Neurology/Adult—49.20 percent; Urgent/Convenient Care/Walk-in—49.35 percent; Nurse Practitioner—49.57 percent; Rheumatology—49.92 percent; Pediatrics—51.29 percent; Cardiology—52.17 percent; Orthopedic Surgery—52.56 percent; Pulmonary Medicine—53.34 percent.

To receive a faxed back information fact sheet about how to obtain a full copy of the database results or a copy of the survey, please contact AMGA at (703) 838–0033—ext. 0 and request the "Patient satisfaction fact sheet".

ATTACHMENT B

DIABETES AND DEPRESSION SCREEN—MAY 1996

There is increasing concern about under diagnosis of depression in medical care. To assist in using the Health Status Questionnaire in identifying individuals at risk for depression, a depression risk screener was developed. The screener consists of a single question, "In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in the things that you usually cared about or enjoyed?" Those who answer yes screen positive for possible depression. Figure 1 presents the percentage of patients in each of the OMC conditions, with sufficient data, who screen positive for depression.

FIGURE 1.—*Depression Screen by Condition*

Condition	*Percent*
Diabetes	33.0
Asthma	27.4
Cataract	23.6
Hip	26.8

Diabetes and Depression Screening

Valid depression screener data are available from 1,373 (86.9 percent) of the 1,580 patients in the AGPA:OMC diabetes data base. There are no significant differences between clinics in the proportions screening positive in diabetic patients. There are significant differences by age, gender, and education. The relationship with age is curvilinear where the proportion of those screening positive peaks in the fifth decade as seen in Figure 2.

FIGURE 2.—*Age and Depression Screen for Diabetes*

Age category	*Percent*
20–29	35.9
30–39	39.1
40–49	40.9
50–59	35.0
60–69	30.1
70+	24.6

More females (36.1 percent) screen positive than males (29.0 percent) and those with lower educational levels have higher proportions that screen positive as seen in Figure 3.

FIGURE 3.—*Education and Depression Screen*

Education category	*Percent*
<=8th grade	50.0
Some high school	34.9
High school graduate	34.9
Some college	34.3
College graduate	26.6
Any post-graduate	20.9

There are no significant differences by marital status or race, although the small number of non-whites in the sample impairs the statistical power.

A higher proportion of type I (IDDM) diabetics screen positive (41.5 percent) than type II's (30.3 percent). Among type II's, higher proportions screen positive as treatment regimen intensifies as seen in table 1. However, there is no difference in average HbA1c levels by HSQ depression screen.

TABLE 1.—TREATMENT AND DEPRESSION SCREENER

[Screen result positive]

	No.	Percent positive
Treatment:		
None/diet	21	20.8
Oral only	81	25.7
Insulin only	127	35.0
Combination	28	38.9

Clinical variables.—There are a number of clinical variables with significant differences in the proportions screening positive depending on the patients' status (see table 2).

TABLE 2.—CLINICAL VARIABLES AND DEPRESSION RISK SCREEN

Variable	With condition		Without condition	
	No.	Percent positive	No.	Percent positive
Hospitalized—non-diabetic cause	51	[1] 43.2	308	31.3
Non proliferative retinopathy	93	39.1	254	30.5
Proliferative retinopathy	43	49.4	310	31.1
History of TIA	19	51.4	342	31.9
History of CVA	23	53.1	339	32.0
Laser Therapy	49	41.5	313	31.6
History of MI	50	41.7	312	31.5

[1] Interpretation: Of those who were hospitalized for non-diabetic reasons, 51 or 43.2 percent screened positive; of those without such a hospitalization, 308 or 31.3 percent screened positive.

DIABETES SCALE SCORES

Those screening positive for depression had significantly lower average scores on all of the diabetic scale scores except for Sugar Monitoring Difficulty as presented in Figure 4. For example, patients screening positive had more general symptoms than those screening negative.

FIGURE 4.—DEPRESSION SCREEN AND THE DIABETES SCALE SCORES [1]

Symptoms	Positive screen	Negative screen
General	67.6	81.8
Cardiopulmonary	86.0	93.7

FIGURE 4.—DEPRESSION SCREEN AND THE DIABETES SCALE SCORES [1]—Continued

Symptoms	Positive screen	Negative screen
Hypoglycemic	75.7	85.7
Sugar monitoring difficulty	67.5	69.5
Leg discomfort	71.2	86.2
Urinary	56.5	67.0
Visual	83.5	93.6

[1] Scale scores range from 0–100 with a higher score being better and were constructed from the diabetes questionnaire. For exact calculation and description of the scales please contact AGPA.

CONCLUSION

Any screening test has properties of sensitivity, specificity, and positive predictive value (PPV), the last of which depends on the prevalence of the condition in the underlying population. The PPV of this screener is estimated to be between 30 and 50 percent. This means that 50 to 70 percent of those screening positive for depression will not have clinical depression according to DSM–IV criteria. However, there are indications that many of these people do have significant problems that are associated with lower levels of health and may lead to higher utilization and decreased satisfaction.

These data suggest that clinicians treating patients with diabetes should have a high index of suspicion for depression and other psycho-social difficulties. Moreover, there are certain sub-groups where the prevalence is even higher.

If you have any comments or questions regarding this report please contact AGPA. Additionally, if you have any suggestions for future reports for any of the AGPA:OMC studies please forward them to AGPA.

STATEMENT OF JOHN C. NELSON, M.D., AMERICAN MEDICAL ASSOCIATION

Senator SPECTER. I would like to now turn to Dr. John Nelson of the Board of Trustees of the American Medical Association. Welcome, Dr. Nelson, the floor is yours.

Dr. NELSON. Thank you, sir.

My name is John C. Nelson, M.D., and I am a practicing obstetrician gynecologist from Salt Lake City, UT, and a member of the board of the AMA. Today, I am pleased to offer our views on what we believe is one of the most important questions that you in the 105th Congress will face, sir, how to safeguard the quality of care for senior citizens.

To date, the health care debate has been on cost, quality, and access; but, as you know, mostly on cost. Certainly, that has got to be looked at. We are, indeed, spending a lot of money. We think way too much of that debate has been focused on cost at the exception of quality. Let me assert, quality controls cost.

If you think not, as a gynecologist I need to diagnose and correctly treat my patient with the ectopic or tubal pregnancy before that pregnancy ruptures when my patient might die. Conversely, I do not want to be sticking laparoscopes or other instruments in that patient if she does not need it. Quality and what we do is what is going to control the cost.

Second, we are very concerned about the patient-physician relationship that has been alluded to. We know that patients want to be able to trust their physicians.

You asked us to speak about Dr. Ware's study, and you have discussed that at great length. Let me simply share with you that JAMA is a peer review journal. It took a very long time and a lot of work for any article, particularly this one, to be published. We

are very proud of that record and that high standard of quality for the journal.

I think one of the points we would draw attention to, sir, is the idea that this simply is a wakeup call. Before we send patients through any kind of care, it needs to be assessed very carefully for its quality.

The AMA is neither pro nor con managed care. To me management care means managing care, taking care of patients. To the extent that the system can give me better information to take care of my patients, I salute that.

If that process or if that system disallows me to give care and does not let me give the care my patient needs, I have great concern about that. What we want to do is to make sure that we pick out those issues where the quality is good and follow those, find the ones that are bad and shun those.

As participants in managed care, which 80 percent of AMA physicians are, we are concerned about making sure that our patients get the care that they need. We also would point out that the Medicare patient is clearly not average, being certainly older and often sicker.

We have already talked about why it took so long for the data to get out. Let me simply say that there was lots of work that needed to be done before the study could be published.

I would also be very careful to remind us that we do not view this, as perhaps we did years ago when we first heard some of the evidence about tobacco, and just discount it. As you know, it took some time for that work to be done. Now where are we with the information we have?

You also asked us to address incentives and disincentives to health care treatment or HMO's. We would recognize that any payment system can have incentives to provide care or not provide care and affect the way that that care was given.

We support, therefore, placing limitations on physician incentives in prepaid health organizations if those incentives were detrimental to patients. Of course, we would want them to be encouraged if they are helpful to patients.

If the plans has incentives for a physician to limit needed health care; that needs to be stopped. If it has incentives to provide appropriate health care, that needs to be encouraged. This occurs, of course, by having full disclosure to patients about plan limitations including incentives to physicians to limit care, et cetera.

We would like to, and hope there will be time in the Q&A to talk about gag practices, not just gag rules. If you ask a group if they have gag rules, they are always going to say no. I am here to tell you that there are some very subtle things that occur which do, in fact, have an effect on how patients treat physicians.

We know, too, again that the patient-physician relationship, regardless of the payment system, is that which needs to be engendered. We also commend HCFA for their work with Health and Human Services on the little booklets they are putting out on helping people to make better decisions in HMO's, and so forth. This explains what needs to be dealt with.

Finally, Mr. Chairman, we commend you for having the courage of your convictions to hold this hearing on such an incredibly important subject. The bottom line for us, I think, is going to be restoring the care in Medicare, making sure that the quality of care is there, irrespective of the plan that the patient chooses.

Thank you very much for allowing me to testify. I look forward to your questions.

Senator SPECTER. Thank you very much, Dr. Nelson. I will pick up the gag practices in the Q&A.

[The statement follows:]

PREPARED STATEMENT OF JOHN C. NELSON

Mr. Chairman and Members of the Subcommittee: My name is John C. Nelson, MD. I am a practicing obstetrician-gynecologist from Salt Lake City, Utah, and a member of the Board of Trustees of the American Medical Association (AMA). Today, I am pleased to offer our views and suggestions concerning what we believe is one of the most important questions the 105th Congress will face—how to safeguard the quality of health care provided to senior citizens. The AMA has long supported reforms that would promote quality and access to care for the elderly and non-elderly by supporting the elements of patient choice, health plan standards and, of course, patient protections in both the public and private sectors. The AMA believes that while the health care debate, to date, has been on cost, quality and access, too much of the discussion has focused on cost and access, rather than quality. We believe that only by preserving the patient-physician relationship can the quality of health care in America be maintained. As more and more Medicare patients are selecting risk-based plans, hearings such as this one are especially important to address concerns and allay unnecessary fears.

WARE STUDY SOUNDS CAUTIONARY NOTE

First, as you requested, we would like to address the research results published by Dr. John Ware, and his colleagues, in the October 2, 1996, issue of the Journal of the American Medical Association (JAMA) (which we would note for the record is a scientifically peer reviewed and independently published journal).

As you know, the Ware study found that elderly patients and poor, chronically ill patients enrolled in managed care had inferior physical health outcomes compared to those patients treated in fee-for-service settings. Clearly, this study should be a wake-up call for all Americans concerned about the negative consequences that can flow from managed care. For this reason, we concur with Dr. Ware that the results "sound a cautionary note to policy-makers who expect overall experience to date with HMO's to generalize to specific subgroups, such as Medicare beneficiaries or the poor," because of their often special and complicated health care needs. The AMA believes that all of America's patients deserve to receive the highest quality of care. We also believe that the elderly, the most predominant beneficiaries of the publicly funded Medicare program, deserve to be safeguarded from potential harm as the nation contemplates turning over the Medicare program to managed care.

This is not to say that we do not believe there is an appropriate role for managed care in the Medicare program. There is such a role and physicians are actively participating in these programs. Over 80 percent of our members participate in some form of managed care arrangement—and for many patients, these plans work well. As Dr. Ware has stated, "for the average chronically ill patient [the results of the study] constitute good news for those who consider HMO's as a solution to rising health care costs." As participants in managed care, AMA members view this positively. We are concerned, however, about Dr. Ware's conclusion that "outcomes were equivalent for the average patient because those who were younger, relatively healthy, and relatively well-off financially did at least as well in HMO's as in the FFS plans." We know that not all Medicare patients may be as fortunate as those described. The AMA believes that all patients, not just healthy, younger and well-off patients are entitled to appropriate care.

Although we are aware that Dr. Ware's observations have been criticized by some for being based on data gathered some time ago, we note that this is a groundbreaking study attempting to explore areas, issues and data that had not been previously studied. While we believe more study is needed, it is highly appro-

priate to be concerned with the fact that the elderly may not be receiving the quality of health care they need, when they need it the most. In the past, managed care representatives have trumpeted the results of published studies in JAMA that have suggested that HMO members received more preventive care in that system of care than in fee-for-service. The Ware study deserves to be considered in the same way. The AMA believes that medical outcomes studies must be reported and discussed because they provide us with a direction for future inquiry and allow us to build a common base of knowledge. We believe that patients benefit from the reporting and discussion of this information regardless of whether the results favor fee-for-service or managed care.

AMA POSITION ON FINANCIAL INCENTIVES AND DISINCENTIVES IN PATIENT TREATMENT

Mr. Chairman, in your request for testimony you asked that we discuss "incentives and disincentives to health care treatment under HMO's." The AMA recognizes that any payment system has incentives that affect the manner and amount of care given. The issue is not incentives, per se, but instead how incentives can best be utilized to achieve both quality and cost containment objectives. The AMA has supported both legislative and regulatory efforts concerning Medicare and Medicaid limitations on physician incentive plans in prepaid health organizations. As such, the AMA strongly believes that full disclosure to patients of health plan limitations, including incentives provided to physicians to limit care, is essential. With full disclosure and understanding, the patient can make an informed choice. Without such information, the patient can only select plans blindly. Regardless of the payment system, the AMA has long held the position that trust is at the foundation of the patient-physician relationship and that this is predicated on the principle that physicians are dedicated first and foremost to serving the needs of their patients. Stemming from this fundamental belief is the view that physicians have a duty to act as patient advocates regardless of the setting. The AMA believes that this duty must not be compromised by inappropriate financial or other incentives.

For example, the AMA strongly supported and continues to support the full implementation of the requirements mandated by the Omnibus Budget Reconciliation Act of 1990 ("OBRA'90") that prohibit payments designed to induce the physician to limit or reduce medically necessary services to a specific individual. The purpose of this and other relevant requirements contained in OBRA'90 was to protect Medicare beneficiaries and Medicaid recipients from the withholding of necessary medical services by regulating the use of financial incentives by prepaid health plans. Consistent with the legislative mandate, the Health Care Financing Administration (HCFA) published in March the final rule (with comment) which provides that physician incentive plans, "may not directly or indirectly, make any specific payment as an inducement to reduce or limit covered medical services." The AMA supports this requirement because we maintain that a physician's ethical responsibility is to advance the patient's best interests. We believe, therefore, that payments designed to induce the withholding of medically necessary care are highly inappropriate. The AMA believes that financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

The AMA is on record in support of the rule published by HCFA as a good first step in protecting patients. While we support this version of the rule, we are concerned that HCFA is about to change the final rule so that it is no longer consonant with the legislative intent. Specifically, under the law, if a physician stands to lose more than 25 percent of his or her income under the managed care contract (because of referrals to specialists or other factors) the published rule requires that the HMO provide reinsurance to the physician to limit his or her financial exposure, thereby cushioning the incentive to undertreat patients.

It is our understanding that HCFA is now poised to change the final regulation, requiring only that the plans produce proof that stop-loss insurance exists, rather than requiring that the plans pay for the stop-loss insurance. Apart from our unhappiness over a significant modification of the final rule by HCFA, we are concerned that plans may now view this as HCFA providing them with the authority to continue the practice of using physician stop-loss insurance as a profit center by marking-up coverage provided to physicians for this essential patient protection. The AMA believes that HCFA's original decision to have the health plan bear the expense of providing stop-loss insurance accurately reflects Congressional intent in this area. Mr. Chairman, we urge you to discuss this matter with HCFA and express your concerns as well.

GENERAL ACCOUNTING OFFICE REPORT HIGHLIGHTS PROBLEMS

Although the focus of this hearing is on the elderly, we would like to commend to the Chairman the recent General Accounting Office (GAO) report requested by Senator Bill Cohen (R–ME) entitled Managed Care Initiatives (GAO/HEHS–96–153R), which was released on September 25, 1996. This report details the various tools managed care plans use to control costs and discusses recent state initiatives that address public fears associated with managed care. While the report does not assess the merits of the many state and regulatory actions concerning managed care providers, the report states the obvious when it says "such state actions, however, are normally taken in response to public concerns." Although Medicare is largely a fee-for-service program, Medicare beneficiaries are moving increasingly to managed care plans.

While the state experience with managed care is not an exact analogy, it does offer a glimpse into the public's thoughts, perceptions and concerns regarding the effects of managed care. As more of the elderly move into managed care programs under Medicare, these concerns will be increasingly raised on the federal level. As the GAO Report suggests, the public has an ongoing issue with specific managed care practices in the private sector, including concerns that physician payment methods may create incentives to underserve patients; that physicians have been "gagged" by plans from disclosing necessary plan and treatment options; and that plans have restricted the patient's choice of physicians and have limited access to specialist care. We disagree with the insurance and managed care industry's characterization of these important actions as "anti-managed care." Instead, because so many of our member physicians participate in managed care, we believe many of these state actions help to allay public fears and should therefore be considered "pro-patient."

PATIENT PROTECTIONS NEEDED

The AMA believes that the one thing the recent health care debates (both health system and Medicare reform) had in common is that Americans want to choose their own physician and continue their relationship with their own personal physician. In fact, some pundits have speculated that the 1992 Senatorial race in Pennsylvania sparked this debate when the successful candidate ran on the slogan "if every criminal has a right to an attorney, shouldn't you have the right to a doctor?" The AMA believes that while trust and choice should be at the heart of any reform proposal, health plan standards and patient protections should be its backbone. We believe that the more choices patients are afforded the more information must be provided in order to give them the appropriate tools to make meaningful choices. The AMA urges that plans be guided by the following principles: disclosure to patients of plan information, rights and responsibilities; appropriate professional involvement in plan medical policy matters; disclosure to patients of plan utilization review policies and procedures; reasonable opportunity for patient choice of plans and physicians; and, reasonable access to physicians and specialists.

DISCLOSURE

Plans should disclose to patients information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. In selecting plans, individuals need information not only outcomes information, but also information describing how the plan operates. Beneficiaries also need to be informed about their health benefits, what they must do to ensure that services are covered, where and from whom they receive services, and how plans compare on items such as quality indicators, patient satisfaction, cost control programs, and grievance and appeals procedures.

Another GAO report requested by Senators Cohen (R–ME) and Pryor (D–AR) entitled Medicare: HCFA Should Release Data to Aid Consumers. Prompt Better HMO Performance, was released last month (GAO/HEHS–97–23). The report suggested that "none of the HMO-specific information HCFA routinely collects will be distributed directly to beneficiaries" and included a number of specific recommendations to remedy this situation. The AMA believes that Medicare beneficiaries are entitled to this information.

In addition, there are legitimate concerns with inappropriate market segmentation and marketing practices designed to attract healthy enrollees in the growing Medicare and Medicaid programs. While plans should be allowed to benefit from competition and their ability to constructively improve the health care delivery process, they should not be allowed to seek out and cover only relatively healthy individuals while avoiding the sicker, more costly elderly. Marketing practices need to be

evaluated as well, and insurance companies should not be allowed to offer physicians and physician groups inducements to reduce or limit medically necessary services provided to patients. The AMA believes that there should be a minimum set of provisions that plans must meet and enrollment procedures that plans must comply with that are fair and avoid inappropriate market segmentation. We would be pleased to work with you, Mr. Chairman, to develop these standards in the future.

As a federally funded program, it is important to ensure that there be some minimum set of services that each plan provides with appropriate incentives for preventive services. Plans should have flexibility as to how they provide the services and should be able to enhance the benefit package to meet customer and market needs. At the same time, plans also need to have arrangements so that enrollees can expect reasonable access to all medically necessary and appropriate care.

DISCLOSURE OF PLAN POLICIES AND PROCEDURES

In order to guarantee fairness and ensure that necessary medical services are provided, procedures must be established that provide enrollees and providers with a system to resolve disputes within the plan. In cases where the grievance or dispute cannot be resolved within the plan, participants should be able to seek independent means to address the problems. We are not confident that HCFA's current appeals process adequately meets this goal. In addition, we believe that physicians involved with Medicare HMO's should, as with fee-for-service physicians, have the ability to appeal HMO denials.

Due to the nature of the patient-physician relationship, physicians should be allowed to seek participation in plans. Physicians should also have the ability to examine with the plan the reasons why participation would not be continued, for example, where involuntary termination occurs.

Mr. Chairman, we would like to take this opportunity to commend HCFA, working in conjunction with the Health and Human Services Office of Inspector General, for recently publishing an important Medicare beneficiary advisory bulletin entitled, "What Medicare Beneficiaries Need To Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights." This advisory bulletin is an excellent example of the type of important information Medicare beneficiaries should have made available to them. In short, the advisory bulletin explains how beneficiaries may get help in finding out an HMO's policies and procedures and where to make complaints if any of their rights have been violated. We believe it is critical that each new Medicare risk contract enrollee be provided with this booklet upon enrollment in an HMO.

APPROPRIATE PROFESSIONAL INVOLVEMENT

We believe that it is the duty of physicians to ensure that their patients receive necessary and appropriate care regardless of the setting or method of payment in which that care is delivered. To make certain that physicians are able to meet this obligation, plans need to provide a process for meaningful physician involvement, such as through a medical staff, in the development of medical policies of the plan. It is also necessary for plans to have procedures and methods that ensure that high quality care is provided, with some degree of flexibility afforded to plans in order to encourage innovations in quality improvement and cost-effective care.

MEDICARE PEER REVIEW ORGANIZATIONS

The AMA continues to support HCFA's Health Care Quality Improvement Program, which specifies an educational and nonpunitive role for Peer Review Organizations (PRO's). Medicare PRO's will have an increasingly important role to play in assuring the quality of care provided by Medicare managed care plans. Medicare risk contract plans are required to contract with a PRO to review whether plan services meet professionally recognized standards of care, including access to appropriate services and use of appropriate settings. Because risk contracts prepay for services to Medicare beneficiaries, the PRO's are not conducting utilization review, per se. By monitoring access to services, however, the PRO's are able to monitor potential underutilization by managed care plans. Recent draft revisions to the PRO Manual link quality in Medicare managed care to utilization by specifying that, in managed care settings, "quality" includes questioning whether appropriate health care services were withheld. This will, for example, allow PRO's to treat patient complaints regarding service denials as quality complaints. The AMA supports this revision because it offers patient protections in Medicare managed care settings. It preserves the patient-physician relationship by enhancing the mechanism whereby patients and physicians can seek to obtain services recommended by physicians, but denied by plans.

DISCLOSURE OF UTILIZATION REVIEW

In plan quality management systems and utilization review programs, it is necessary that these programs operate to enhance patient care and are based on sound scientific and medical information. Cost alone cannot be allowed to drive quality. Those who are involved in final decisions should be knowledgeable and qualified in the area they are reviewing. Procedures need to be fair and prompt.

AMERICAN MEDICAL ACCREDITATION PROGRAM (AMAP)

Because we believe all players in the health care system should be held accountable, in June, the AMA's Board of Trustees approved the development of a comprehensive program for accrediting physicians to replace existing, duplicative credentialing, office visit and profiling activities. This physician accreditation program would become the quality standard for all public and private health plans. This program is called the American Medical Accreditation Program (AMAP). The program will have five basic components to assess a physician's performance on a periodic basis including credentials, personal qualifications, environment of care, clinical performance and patient care results. The accreditation would be recognized by other organizations to meet their standards and replace multiple reviews of physicians. The AMA believes that AMAP will afford us the opportunity to do what we have historically done best—to establish professional standards and develop a mechanism, through our ability as a national organization, to gain consensus of the relevant parties and help patients.

THE NATIONAL PATIENT SAFETY FOUNDATION

The AMA is committed to increasing patient safety for the elderly and for all patients. Accordingly, the AMA recently launched a major new initiative dedicated to ensuring that all patients in all settings receive health care services safely. In short, the AMA has created the National Patient Safety Foundation (NPSF) to further enhance patient safety in light of the escalating complexity in the health care system. To maximize prospects for success in the increasingly integrated health care environment, we believe this endeavor must be a collaborative enterprise, involving representation from every interested sector of the health care community. The NPSF will address the issues caused by liability concerns and the increased public concern for personal risk in all aspects of life. It is our hope that patients will see in our effort the seriousness with which the AMA and its committed partners regard their difficult and sometimes tragic experience, as well as our commitment to improving safety for the patients of the future.

CONCLUSION

In conclusion, Mr. Chairman, thank you for the opportunity to testify here today. We commend you for holding this important hearing. The AMA believes that safeguarding the health care of our senior citizens will be one of the most important issues the 105th Congress will face. The AMA supports major modifications to the Medicare program to increase choice for beneficiaries. In developing our proposal, we have addressed concerns about the effect of certain systems of care on quality of, and access to, necessary services. In supporting pluralism of delivery systems and choice, we firmly believe that quality can be assured, assuming the appropriate safeguards are enacted. The AMA stands ready to work with you, Mr. Chairman, and Members of your Subcommittee on these important matters in the future.

STATEMENT OF LINDA PEENO, M.D., PATIENT ACCESS TO SPECIALTY CARE COALITION

Senator SPECTER. I would like to turn now to Dr. Linda Peeno representing the Patient Access to Specialty Care Coalition. Welcome, Dr. Peeno, and the floor is yours.

Dr. PEENO. Thank you, Senator Specter. I appreciate the opportunity to be here. My name is Linda Peeno. I am a physician. Over the past 15 years, I have worked in medical management and ethics, which has included positions of medical review and medical director and three prominent managed care companies.

I know how managed care plans operate, and I would like to share with you some of the practices I have seen firsthand that

managed care organizations use to exploit patients for the economic benefit of some plans.

I am here on the behalf of the Patient Access to Specialty Care Coalition, which is made up of over 120 national organizations representing consumers and providers of medical services concern that the focus of health care must be on patients and quality of their medical care.

From my experiences, I can confirm that patients need, one, access to doctors and specialists of choice; two, full disclosure of information on all treatment options; three, a fair and expedient appeals process; and, four, protections from the existence of gag conditions. Here I would agree with Dr. Nelson, we are talking about more than just clauses and financial incentives.

All patients should be guaranteed uniform protections and standards to ensure that they receive access to unrestricted quality care. This issue becomes increasingly important for older Americans who on the average have higher utilization rates and more needs for care by specialists. The denial of access to appropriate doctors and specialists can have fatal consequences.

For example, a recent study sponsored by the Agency for Health Care Policy Research just this past month, shows specifically that the morbidity rates for stroke victims that have been managed by neurologists are far lower than the morbidity rates of patients managed by general medical practitioners.

Although there are many ways that managed care organizations can limit care, the most egregious way is when they rely on the trust that patients have in their doctors and their belief in the doctor-patient relationship.

Plans bank on the fact that patients trust their physicians and do not yet question medical decisions and how they are constrained by such things as the gag conditions and the financial incentives.

Given the age and socioeconomic profiles of most Medicare beneficiaries, many tend to suffer from long-term conditions and require complex treatments. In addition, these clinical needs occur in a backdrop of other personal needs, loss of spouses, companions, or friends, limited mobility, fixed incomes, and other conditions which compound any other medical need they may have.

More seriously, there may be educational difficulties that restrict the beneficiary's understanding of his or her medical options. Given the changing nature of the business of health care, physicians are facing incredible pressures not only to provide care, but to turn profit for managed care organizations that provide their income.

As a physician, I find it completely unethical to demand that medical professionals base their care on financial incentives or considerations that induce them to withhold or deny care.

Even when patients are aware they are not getting the best care, my experience as a medical director taught me that HMO's and other managed care organizations often purposely use vague claims and complicated administrative procedures to confuse and intimidate the more vulnerable patient populations such as Medicare beneficiaries.

Now, while I applaud HCFA's quick response to correcting these flaws in the appeals process for seniors, it is not enough. We need baseline protections for quality of care. I am adamantly opposed to

the current system whose financial success increasingly depends upon withholding information, limiting choice, and eroding trust.

We are harming patients, physicians, and the reputation of the American health care system. I think that the outcome out of this hearing is that we should take an honest and a hard look at the system we are creating, especially the serious challenges proposed by denial of access and choice, restrictions on medical communication, existence of financial incentives to limit care, and insufficient appeals process.

PREPARED STATEMENT

I urge Congress and the administration to pass laws that would correct patient denial of access and choice and eliminate these conditions that restrict physicians' communications and to implement a fair and expeditious appeal process.

Thank you for your consideration of these issues.

[The statement follows:]

PREPARED STATEMENT OF LINDA PEENO

INTRODUCTION

My name is Linda Peeno. I am a physician with training in Internal Medicine and Infectious Diseases. For the past fifteen years, I have worked in medical management and ethics, which has included jobs in three prominent managed care companies. In two of these positions, I was the Medical Director, charged with protecting the interests of the plans through medical limitations. I have also been the Medical Director of a community hospital whose primary patient base was Medicare beneficiaries. I quickly discovered that all my work—whether hospital or health plan—involved giving medical validation to bottom-line demands. When I realized that this was inherent to the work of a physician executive, I made an ethical decision to leave the lucrative field of medical management and managed care to aggressively pursue a role as a health care ethicist and patient educator. I am here on behalf of the Patient Access to Specialty Care Coalition, which is made up of over 120 national organizations representing consumers and providers of medical services. The Coalition members are united in their concern that the focus of health care must be on patients and the quality of their medical care. I cannot overstate the importance of a legislative solution to ensure that patients, especially senior citizens, have complete understanding of their medical rights and access to the physicians and care they need—from prevention to treatment.

SUMMARY

As a former HMO medical director, I know well the methods managed care organizations employ to achieve the lowest cost and the highest profits, often to the detriment of the patient. Since leaving my corporate work, I have dedicated my professional work to the reform of a system for which I am partially responsible for encouraging. This work is urgent, for during the past decade, we have witnessed the birth of an industry increasingly removed from anything resembling health or care.

We have entered an era in which health care is a complicated issue even for those who know something about it. Certainly, it is now beyond the understanding of most consumers and patients. Indeed, many Medicare beneficiaries do not understand even the basic differences between traditional Medicare and HMO's and may confuse HMO's with supplemental Medigap insurance (GAO report 10/23). That is why I believe that all patients should be guaranteed uniform protections and standards to assure that they are receiving unrestricted quality care, regardless of the plan or type of insurance they are receiving. This issue becomes increasingly important for older Americans, who on average have higher utilization rates and more need for care by specialists.

As more people of all ages are moving into managed care, these practices are causing increasingly negative consequences to patient's medical outcomes, as outlined in Dr. Ware's study. I witnessed this first hand in my own work. When we are focused on short term economic gains as measured by diminished testing, decreased lengths of stay, and limitations to specialty care, we lose sight of the total

patient need. Until we are able to do thorough outcome studies, we may never know the real price we will eventually pay for these expedient controls. Dr. Ware's study begins to give us valuable information by validating what I predicted in my own work and subsequently found confirmed through patient stories. When particular populations with specific needs are adversely affected by any health system, it is time to make real changes. The fact that seniors enrolled in HMO's have worse health outcomes than those in the Medicare fee-for-service plan is unconscionable. With the focus for new business now on Medicare beneficiaries, managed care organizations must finally be made accountable for their actions before society incurs more serious and higher costs in other ways.

My experience as a managed care executive taught me that HMO's purposely use vague claims and complicated administrative procedures to confuse and intimidate the more vulnerable patient population, such as Medicare beneficiaries. During one of my jobs as a medical reviewer, I experienced firsthand the exploitation of Medicare beneficiaries as they were moved into a managed care plan. I was present during many actuarial discussions, in which we were educated about the economic advantages of receiving fixed premiums from a population with a certain attrition rate. Furthermore, this population could be relied upon to trust authority, especially medical authority, and, we (the medical reviewers) were told it would be easy to manage such a group and their doctors. Managed care organizations rely on this trust that patients have in their doctors and their belief that doctors will always do what is best for the patient. Unfortunately, I know the truth. Doctors, specialists and medical services providers are restricted in their ability to give care by cost-saving "guidelines" enforced on them by the HMO's. Given the changing nature of the business of health care, physicians are facing incredible pressures, not only to provide care, but also to turn a profit for the managed care organization that provides their salary.

Medicare beneficiaries require more sympathetic care than the average health care consumer. Given the age and socioeconomic profiles of most Medicare beneficiaries, many tend to suffer from long-term conditions and require complex treatments. In addition, these clinical needs occur in a backdrop of other personal needs—loss of spouses, companions or friends, limited mobility, fixed incomes, etc.—which compound any medical condition. More seriously, there may be educational difficulties that restrict the beneficiary's understanding of his or her medical options. Under fee-for-service, Medicare beneficiaries, or those caring for them, have great control over the types of treatments available and there are no incentives to withhold care. By enrolling in an HMO, beneficiaries are faced with significant differences in the provision of benefits, premiums and networks of providers—a whole system that is foreign to anything in their experience.

If all we do is simplify the managed care rules and regulations regarding claims and appeals, we are doing a great disservice to the millions of older Americans now enrolled in managed care.

It provides for no protections to vulnerable populations, as we continue to ration care at the level of the individual, often through deception and denial. And while I understand that HCFA is now working to correct flaws in the appeals process for seniors, it is not enough.

The central issue remains access to appropriate care and preservation of the means to obtain it without obstacles. We must ensure that all health care consumers including seniors are protected by uniform standards, and are assured access to the specialists and treatments they need. A crisis of well-being and life is not the time when one should agonize over issues of confidence, trust, integrity and compassion.

Given the excesses of the past, I am not opposed to the managed care model. The move toward coordinated, appropriate care with an emphasis on prevention and maintenance of health should be a part of all health care reform. Moreover, any health system should be well-grounded in a strong ethical foundation. However, as a medical doctor and health care consumer, I am opposed to practices of managed care organizations which result in the sacrifice of the well-being of the patient for the sake of controlling costs. In addition, I am adamantly opposed to a system whose success depends upon withholding information, limiting choice, and eroding trust. This harms the patient and the reputation of the American health care system. We must take an honest, hard look at the system we are creating, especially the serious challenges posed by: Denial of access and choice; restrictions on medical communication; existence of financial incentives to limit care; and insufficient appeals process. I will examine each of these areas in turn to discuss how the quality of care for Medicare beneficiaries is harmed via these and other managed care practices.

ACCESS AND CHOICE

Let us remember that when we are discussing Medicare beneficiaries we are talking about a vulnerable segment of the population who can easily be overwhelmed by paperwork and bureaucratic institutions. Many older Americans are alone, without family or a network of support. When combined with the possibility of a life threatening or chronic illness, the irrational hurdles imposed by HMO's and other managed care plans become daunting.

The financial success of managed care organizations is based on centralizing care to improve cost efficiencies. By funneling all care through a primary care physician, it is argued that the patient receives coordinated care. While it is important that a patient's care be unified, I would argue that primary care physicians are more often used as gatekeepers to control and limit care. For seniors this translates to a restriction of treatments and referrals to specialists which they may need. The situation is worsened when many seniors are confused about whether or not the doctor or specialists they are currently seeing are participating in their new HMO. The requirement to change doctors, such as a cardiologist or rheumatologist, can be emotionally traumatic and interrupt the cycle of care. A brief visit with a new doctor can never replace the extensive information base and long term relationships built carefully over years of experiences together.

Patients often find that even though they are allocated a doctor, each time they visit they may see a different physician, as frequently whole practices are co-opted by an HMO. In such a setting, doctors are given guidelines or incentives to ensure that certain numbers of patients are seen per hour, per day or per week.

In a national survey conducted last year by the Patient Access to Specialty Care Coalition (September 1995), three out of four Americans aged 50 and over said they would not join a Medicare managed care health plan without the freedom to continue to see their current doctor or turn directly to a specialist when they become ill. I understand that managed care is a viable solution for containing health care costs, but for Medicare beneficiaries there must be an effort to ensure care is delivered with a minimum of obstacles.

More than half of Medicare recipients have chronic conditions which are more suited to specialist care. Studies have shown that patients under specialist care recover more quickly and effectively and can save money. For example, older people who suffer a stroke have a better chance of survival if they receive hospital care from a neurologist rather than a general internist (Duke University's Center for Health Policy Research and Education, 11/05/96). To date, HMO plans for Medicare patients, have failed to adequately address special needs of seniors with chronic conditions and special socioeconomic needs. Whatever the plan, choice must remain preeminent.This can occur by mandating a point-of-service option that would enable patients to seek medical attention from specialists whose care they may need or choose.

Of course, this must not include prohibitive co-payments or other economic disadvantages that would defeat the purpose. In this way, beneficiaries would not be required to disenroll in order to receive the kind of care to which they are entitled. Quality of care requires freedom of choice. If seniors are satisfied with the care they receive inside their Medicare managed care network, they won't choose to access doctors and specialists outside the group. But without this freedom, seniors are locked into a rigid system which may or may not give them the kind of care they need and deserve.

Most importantly, it is affordable to give beneficiaries choice of doctors. Study after study has shown that a patient's right to choose can be preserved while saving the Medicare system money at the same time. The Congressional Budget Office testified last year that, "The POS option would permit Medicare enrollees to go to providers out of the HMO's panel when they want to, and yet not need to increase benefit costs for either the HMO or Medicare."

Ensuring choice means ensuring informed choice. This committee could do seniors a great service by investigating managed care marketing techniques. Although this is a problem across the entire managed care industry, the glossy marketing literature and warm advertising that HMO's use to recruit seniors is especially misleading. The massive profits generated by managed care are fueling this drive to recruit Medicare beneficiaries. However, this advertising does not provide the consumer with the appropriate information to make an informed decision. Attractive marketing schemes promise free services, prevention measures, and ease of use, while avoiding vital information about what happens when illness strikes. Seniors are rarely, if ever, told what it means to have a physician who functions as a gatekeeper, or the implications of a restricted network, much less the meaning of something critical like medical necessity determinations. And while a hallmark of our

system is "buyer beware," I would argue that health care delivery must be viewed as more than a business. When the choice of plans can mean the difference between staying healthy or suffering, we must ensure there are proper regulations to protect consumers. As the recent GAO report concludes that Medicare beneficiaries need:

—Standard formats and terminology in HMO's informational materials to curb confusion and provide appropriate information;

—Benefit and cost comparisons charts with all Medicare HMO options available for each market area to provide an overview of all plan options; and

—Wide distribution of HMO's disenrollment rates, complaint rates, and summary results of HCFA's site monitoring visits to ensure self-regulating mechanism for HMO's to follow.

A recent Patient Access to Specialty Care Coalition national omnibus survey found that over half the respondents felt that they did not have enough information about how their health plan operated. As the August 1 Institute of Medicine report suggests, the number of health plan options should be expanded, but only after the federal government and insurers take steps to make all health plans more accountable and understandable to the elderly. Many of the 70,000 Medicare beneficiaries who enroll in managed care plans each month do not have enough information to choose the best plan or to understand their coverage after they have enrolled.

GAG CLAUSES

Managed care can be better described as managed silence. Despite claims less than six months ago from the American Association of Health Plans at a Ways and Means Committee hearing that gag clauses do not exist, prominent managed care companies, such as Humana and U.S. Healthcare, have publicly banned these provisions from their contracts. While I approve of these moves, this is only the first step. Even without explicit gag clauses, there are still contractual conditions that create implicit gag conditions. We need uniform protections, as the previous Congress tried to enact, to abolish gag rules—explicit and implicit—that destroy the heart of medical communication. As a former HMO employee, I know that these control mechanisms will continue to exist without legislation.

We are learning daily how managed care succeeds to the extent that it manages physicians—through financial incentives/disincentives, provider profiling and utilization standards, stringent medical policies with medical necessity determinations, and network limitations. When primary care physicians are restricted additionally in what they can tell their patients about their finances or available treatment options and referrals, the care of patients can be seriously endangered. As a medical director, I knew my job depended upon tight controls of access and distribution. When patients or physicians requested costly care to specialists and outside providers, I had to deny these services to avoid black marks on my own performance assessment. Medical/economic management is much easier—and I was a more "successful" medical director—when physicians are silenced and patients are ignorant. I am not the first to point out the devastating effect this has had on the doctor/patient relationship. Our national survey found that 97 percent of respondents felt they had the right to know if their doctor had such a contract and over 80 percent agreed that they would not sign up for a plan, if they knew their doctor was restricted by such contracts. When consumers understand what is happening, we will see a revolt against such a system.

On this current course, we are undermining the very essence of the profession of medicine. Counting college, I have had nearly fourteen years of advanced education. Most physicians train 7–8 years to do their work. Some specialties require as much as 11–12 years of medical school and residency after college. When individuals and society invest this much time and resources in training, that professional medical opinion and judgment should be valued. When we turn around and discount that training and professionalism, through gag clauses and other mechanisms then it is as if we have intentionally destroyed qualified judgment. When HMO's and managed care organizations reduce medicine to technical manuals administered by medically undertrained, and even untrained, workers and physicians practicing from a distance, they devalue more than the physicians. They make a mockery of the care of patients.

FINANCIAL INCENTIVES AND DISINCENTIVES

The bottom line of managed care is cash not care. I know this from my previous work. Saving money is often put ahead of saving lives. The point of greatest control lies with the gatekeeper. The most effective means to do this is through capitation. Under this payment arrangement, primary care physicians are paid a fixed amount for Medicare beneficiaries, regardless of the number of medical services rendered.

It is therefore not surprising that doctors will restrict the amount of care they provide to patients—after all this is the intended goal. Whether the return is small or large, physicians make every decision conscious that any expenditure diminishes the pool. Since the line between unnecessary and necessary care is not as clear as non-medical executives would like to believe, we do not know when it is crossed. We do not know the myriad of instances of daily, added misery created by delaying or withholding appropriate care.

Knowing the conditions under which a treating physician is making decisions is intrinsic to informed consent—a basic tenet of medical ethics. Our survey found that 95 percent of respondents felt they had the right to know if their doctor had a contract containing financial incentives to encourage the doctor to limit the type of care. It should be of no surprise to anyone that most patients would not feel they could trust a physician who no longer puts their best interest primary. The essence of the doctor-patient relationship is destroyed.

We cannot perpetuate the myth that physicians will somehow do the right thing. I was party to the HMO contract design, especially for physicians. It is common knowledge in the health care business that few physicians read, much less understand, most of the terms of the contracts they sign for HMO's and other managed care organizations. Even if they did, they have little bargaining power, and virtually no room for significant negotiation. It is economic suicide for a physician to be excluded, whether by choice or force. The increasing economic vulnerability of most physicians, make them greater prey for shocking contractual conditions. I have seen contracts in which physicians were capitated, paid additional bonuses for added cost-saving, and then, if those incentives were not enough, they were penalized economically if the plan lost money. How can a physician practice under such conditions?

As we now know, health care is a business that in order for physicians to stay employed, they are forced to accept HMO practices often against their better judgment. Just recently, I attended a session on managed care for primary care physicians for continuing education credit. The entire three hour session focused on the economics of managed care and how to make it work for your practice. There was no mention of clinical or ethical issues surrounding this new way of doing business. The patient is quickly becoming an asset to the degree that he or she brings premium money into a pool, and a liability to the degree that the pool is depleted. Instead of talking about the clinical management of patients, physicians now attend meetings on the economic management of those potential black holes of care.

APPEALS PROCESS

Even when people are aware that they are not getting the best care, there are often no clear cut avenues of appeal within the managed care environment. In fact, the very act of appeal may be a foreign notion to persons who still think that they can trust the decisions of their insurance company and their doctor. I support efforts to ensure that an easily understood grievance process is part of every managed care plan. This is especially important for disadvantaged and vulnerable populations. Many patients with special needs are accustomed to encountering systems of authority that are unwieldy and unapproachable. The poor and elderly are very likely to capitulate to medical management decisions regarding care without ever realizing that appeal is available, or, if they do, understanding how to go about doing it. When increasing numbers of these vulnerable populations are forced, from cost-saving changes in Medicare, into managed care plans, they potentially will suffer greatly. These vulnerable populations are often the least equipped to adapt to the changing health care. We may never know the true extent of these changes, unless the grievance process is simple, accessible, open and fair.

As a medical director, I routinely denied patients treatments or specialist visits because I did not have sufficient time nor adequate information to fully review them. Initially, I justified this with my belief that if the patient's need was really great, then the patient could appeal the denial and receive the necessary care. What amazed me, was that patients rarely appealed. It has taken me years and many conversations across this country to understand that most managed care members do not know about the availability of appeal, and the ones who have accessed it felt that it was a sham.

In addition, I was part of the corporate strategy to establish complex rules for authorizations, referrals and network availability in order to make "technical denials" possible (e.g., failing to go through convoluted procedures set out in a "certificate of coverage," which we knew few persons ever read, would be grounds for denial of payment).

As the present system stands, many plans have unfair, complex and lengthy appeals processes. It is not surprising that most patients do not appeal HMO decisions. For Medicare beneficiaries the decision to appeal is even more intimidating. The reasoning is simple: patients trust their doctors' judgment. This is precisely the premise that the HMO's exploit. For those few patients who do appeal, they encounter countless obstacles. Often the process is incredibly lengthy. A patient may be in significantly worse health by the time the conflict is resolved. Some plans impose time limits on the how late the claim can be submitted, in addition to requiring complex and lengthy forms be completed. Furthermore, many patients are unaware that HMO's do not maintain independent appeals boards which essentially results in the fox guarding the chicken coop. As a medical director who denied claims, I also was responsible for reviewing them during the appeals process. Despite my considerable efforts to encourage the creation of a position on the appeals board for a consumer/patient representative, none of the managed care organizations with whom I worked considered this addition as a benefit to its members. In fact, it was something to be avoided, for not only would it have introduced outside objectivity, it would have meant the internal processes, over calculated to the detriment of consumers, could potentially become public.

This reiterates my point that HMO's and managed care organizations know their practices intimidate and confuse patients. A recently released report by the Medicare Rights Center (10/15/96) found that a vast number of Medicare beneficiaries are wrongfully denied coverage of health care services as well as foregoing necessary care because they do not understand their appeal rights.

I maintain that all patients have the right to a fair and expeditious appeals process. The process should be well-known and readily available. It should include outside members and some means to make external assessments, to insure independent attention to member and provider complaints. The process by which plans handle complaints and their resolutions should be standardized, as well as publicly available to enable consumers to make fair and informed assessments of plans' performances.

CONCLUSION

I know the managed care system from the inside. As a physician, I climbed the HMO ladder only to find my primary responsibility was not the health care of my members, but the profitability of my employer. I know the dangers to patients are real. Although many people are quick to extol the virtues of managed care: the ease, the affordability, and the focus on prevention of illness and regular check-ups. The real test comes when a patient is sick and requires extensive or expensive care. A twenty-first century health care system should be measured by its preventive measures, as well as its expeditious and compassionate care of illness and disease when it strikes.

Most of the technological breakthroughs in medicine have occurred in the United States, where the innovation and expertise of our physicians has made the American system the best in the world. Let's keep it that way. We must not let the business of health care overshadow the delivery of health care. We must not gag doctors or penalize them for speaking their minds on treatment issues. We must not reward physicians for withholding care and punish them for giving it. We must ensure there are adequate protections for doctors and patients to ensure that affordable, high quality health care remains the norm, and not the exception for patients of all ages.

Thank you for your consideration of these issues.

Senator SPECTER. Thank you very much, Dr. Peeno. Beginning with your testimony, you refer to vague provisions which deny access. Can you be a little more explicit or perhaps illustrate the kind of a vague provision you have in mind?

Dr. PEENO. Well, the nature of managed care is to manage care, you know, the physicians who deliver it, and the patients who receive it. You know, in my experience as a medical director, my job was to create both covert and overt ways to limit physicians' decisionmaking and limit access for patients to specialists.

Senator SPECTER. Where are you the medical director?

Dr. PEENO. Well, I am no longer the medical director.

Senator SPECTER. Where were you?

Dr. PEENO. I was at one time with Humana, I was with Blue Cross-Blue Shield of Kentucky, and I was a medical director of one of the plans managed by a major managed care company out of Minnesota, Partners.

Senator SPECTER. When you talk about the Congress enacting legislation, do you have anything specifically in mind? You heard the testimony of Dr. Ware and Dr. Wilensky telling us, in effect, keep out. What do you think of that?

Dr. PEENO. Well, I would disagree. I think that the managed care processes have evolved to a point where somebody has to intervene. The most appropriate place, I think, is legislatively in order to protect the American public. Consumer protections do not work because we have very few consumer protections that apply to the kind of experiences that consumers have.

Senator SPECTER. What did you think about legislation requiring at least a 48-hour stay for a mother having delivered a child?

Dr. PEENO. Well, I think it is a sad commentary that the governmental body of this country has to get into making that kind of legislation, but I certainly applaud it. I can share experiences and stories of patients who have been significantly harmed by managed care plans restricting prenatal—I mean, postnatal care.

Senator SPECTER. What do you think about the limitations on the hospitalization on mastectomies?

Dr. PEENO. Well, again I think, you know, it brings up the same issue. I mean, a governmental body should not be involved in making these kinds of decisions. It is, I think, a testimony to how far the business of health care is intruding into the real care of patients.

I mean, we should be making decisions about patient care based on the individual patient's needs, the conditions, and all of the kinds of factors that are involved in that particular need, and not according to some sort of rule or average determined by the industry or, you know, God forbid some legislation that has to come in a State or Federal level.

When we push those things so far that we need to intervene in order to protect the public, I think we are going to have to do that.

Senator SPECTER. Let me make a comment to the panel as a whole, which I made earlier, that the subcommittee would be very interested in any specifics you have on the application of the so-called "gag rule," the hard facts, as to where we are going or the hard facts on the limitations of medical care where the profit incentive is excessive.

[The information follows:]

MANAGEMENT BY IMPEDIMENT: IMPLICIT CONDITIONS OF PHYSICIAN CONTROL AND SOME IMPLICATIONS FOR PATIENT CARE

INTRODUCTION

Imagine this as a front page story in a national newspaper: We have a critical natural resource, which millions of dollars have gone to develop. This resource is vital, for ultimately every human life will need it in some way at some point in time. The public comes to know that it is being misused and even wasted. Would there be an outcry? Of course.

Now consider this scenario: we take the best and brightest college students and educate them for at least eight more years in one of the most rigorous professional programs of any field of study. We invest millions of dollars in their training. We grant them the privilege to enter into the deepest of human relationships—literally

giving them power over life and death. We test them, license them, monitor them, and continue to educate them—for the field in which they have entered changes constantly. These individuals are a precious resource, for indeed one only has to look at societies in which such professionals are poorly trained to understand this. Now, imagine that we take these valuable individuals and begin to constrain their knowledge, their decision-making, their actions—in effect eroding our meticulous and expensive investments. Should there be outrage here too? Certainly.

Why then are we allowing this to happen to the profession of medicine? Not only does it make little sense, it may in fact represent an act of suicide by the society which permits it. As we learn daily from ecology, a vital system is not easily replaced, if it can be at all. Surely we cannot continue to change the practice of medicine without inducing serious, and possibly irreparable, consequences.

I realize that all professions need to be monitored and regulated by some means, and I do not want to appear to claim that the practice of medicine should be exempt from any sort of restrictions. My concern, especially for this analysis, is to help understand how we are eroding the profession of medicine to the detriment of the practice and the care of patients by some managed care practices. This can be best understood by examining the explicit, as well as implicit, impediments used to control physician decision-making and actions under the system we have come to know as managed care.

Despite the current conflict in health care, there is one indisputable fact: we have entered fully into the "managed care" era of medicine. According to a leading textbook on "managed care," this term describes a health system which uses "financial incentives and management controls" to direct patients to "efficient providers who are responsible for giving appropriate medical care in cost-effective treatment settings." This same source, considered an industry textbook, states that the goal of such a system is to manage patients and physicians, by redefining what is best for the patient and how to achieve it economically. There is no subterfuge here. To work, managed care must alter the decision-making of physicians by interjecting complex management methods into the doctor-patient relationship.[1]

With this kind of explicit statement of purpose, why is there little investigation into the methods of management? From the standpoint of a business only, there are certain principles by which practices and consequences of management can be evaluated, such as honesty, fairness, integrity, disclosure, trust, accountability. No human endeavor is free from ethical considerations, especially management, which, by its nature, involves directing or controlling something toward an end—an activity fraught with ethical questions. From the choice of end to the choice of means to achieve that end, the way is laden with ethical issues. There is no business now in which can be clearer than that of medicine and healthcare.

In the pre-managed care days, the division between medical delivery and payment was more distinct. Without getting into whether this separation was good or bad, we can discuss the mechanics of how clinical care occurred. Let us take a simple case of chest pain in an aging male: He experiences a disturbing change in his health and seeks the advice of a physician. His physician takes a medical history, does an exam, and works through a differential diagnosis, moving from the most acute and serious possibilities to the less urgent causes for the complaint. Based upon the physician's assessment of likely causes, he or she may treat the patient conservatively, suggesting dietary and lifestyle changes. If the physician believes there is urgency then he or she may order laboratory tests or diagnostics studies to rule in or out the more serious, life-threatening diagnoses. As a result of additional information gained during this phase, the physician may choose to admit the patient to the hospital for a procedure or for surgery. All of this proceeds through an analysis dependent upon the clinical acumen and expertise of the physician. Presuming the patient has health insurance, at some endpoint claims are submitted to the insurance company for payment. Of course, we know that physicians are no different than any other professional and payment structures do effect decision-making. However, inherently professionals have a responsibility to train, license, and monitor their ranks for the preservation of the profession as a whole. Presumably, the degree to which any profession does this internally, there is less need for external supervision and control.

Regardless of the reasons for a shift to managed care, it is certain that we have entered into an era in which there are blurred distinctions between delivery and payment. In fact, the hallmark of managed care is, as the definition above claims, the integration of medical services and finances. In such an arrangement, physicians are no longer independent, autonomous professionals. Health care is managed to the

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[1] Peter Boland, Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions, p. 3.

extent that physicians (and patients) are managed. This control of physicians has proceeded insidiously, and the practice of medicine is no longer by physicians alone. Many would argue that this is better, that any professional should be scrutinized in proportion to the power they carry over the lives of others. For public and self protection, we must ask ourselves: What methods are used to manage physicians? What is the aggregate effect of the various methods? What are the consequences to patient care? What are the basic considerations for future reform?

METHODS FOR PHYSICIAN MANAGEMENT

A leading health industry text claims that the management of physicians is one of the "common operational problems" for managed care organizations. Failing to deal with "difficult or noncompliant physicians" can result in rising expenses, ill effects on members, and negative morale.[2] Despite this internal admonition, nearly every managed care contract holds itself out to the public as having an "independent contractor" relationship between plan and physician. A member will be told in various ways that their physician will exercise independent medical judgment in their care. Indeed, the managed care industry banks on this remnant belief in autonomy from the fee-for-service era. All the while they are fully aware that they would not be managed care if they did not have extensive methods used to ensure that their participating physicians were kept in line with the plan's ends. So the idea of independent physicians is more than wishful thinking on the part of managed care plans. The logical impossibility of independent decision-making midst the kinds of methods used to manage physicians makes this claim blatantly fraudulent. This becomes clear if we work through how management of care, especially the implicit methods, actually works.

The evolution of managed care processes, as it relates to physician management, can be understood in terms of the ways in which a plan intercedes into the patient/physician relationship. On this timeline of patient/physician interaction, three phases are significant: Post-care controls: methods occurring after care is delivered; Intra-care controls: methods occurring during the delivery of care; Pre-care controls: methods occurring before any particular patient receives care. It is important to note before going into detail that these divisions are somewhat artificial. They are most effective when interrelated and working in concert. As seen below, data compiled on physician's past practices can be used to create profiles designed to change current and future care decisions.

Post-care processes / controls

—Retrospective review for utilization/quality assessment, "medical necessity", and coverage issues

—Aggregate profiling of provider network to assess and determine normative statistical standards for utilization, e.g. lengths-of-stay, admissions per thousand, referral rates, etc.

—Physician monitoring and profiling, with individual and comparative utilization and economic report cards

—Economic credentialing

Post-care processes involve all the management processes used after some service has been rendered, best represented by retrospective review of claims and charts to assess appropriateness of medical treatment and charges. Although the results of such reviews do not effect the specific patient event in question, they can have sentinel effects on future decision-making. For example, if a hospital documented that a surgeon was removing too many "normal" appendices, such information could be used to rein in an aggressive (or greedy) physician, or identify a physician who may need additional training in diagnostics. Similarly, if a physician admits too many sick elderly patients, such information could be used to identify the physician as "wrong" (expensive) for the hospital, or a plan. This kind of review was commonly used before managed care gained prominence. As with most of these activities, it is not the methods itself which is questionable, but the ends to which it is used which should concern us.

With the entrenchment of managed care, a new kind of retrospective management developed. Information management enables plans and hospitals to do extensive physician monitoring and profiling. Although informative and educational, such data is often used to change physician behavior toward a norm determined by the managed care plan or the industry as a whole. This is particularly true when the data provide statistical quantifications, such as length-of-stay, admissions-per-thousand, referral rates, etc. With such report cards, certain physicians will fall away from the

[2] Peter R. Kongstvedt, Essentials of Managed Health Care, p. 287.

median. These physicians, known in the industry as "outliers," become immediate, identifiable targets for control. Since such reports are rarely accompanied by qualitative, clinical information on actual patient conditions or outcomes, physicians are left with little real information about their practice patterns. This means that one ceases to be an outlier less by improving clinical care and more by changing numbers.

For example, OB/GYN's are regularly profiled on lengths-of-stays for the maternity patients. If the norm for a specific plan is 1.7 days, and a particular physician has a length-of-stay of 2.4 days, he or she may appear as an "outlier" on a report which compares him or her to all of the plan's OB/GYN's. If the physician is worried about maintaining participation in the network, receiving a bonus or return of a "withhold," or simply appearing to be a "compliant, good" managed care doctor, he or she will begin to do what is necessary to lower the length-of-stay. The plan does not even need a twenty-four hour policy if they indicate in some way that the norm they prefer is a length-of-stay of 1.0, or if the physician knows his or her withhold/ bonus will be greater is the length-of-stay is closer to 1.0. When there are no report cards indicating complication rates to mother or baby from premature discharges and there are no incentives for providing patient education or home health follow-up, the guiding factor will be staying at the "norm," set either by the plan, the financial arrangement or the physician's own colleagues. The net result will be a push of all patients to the lowest possible stay, striving to make the magic number. Even with the mandates from Congress, indirect pressures ensure that physicians will make decisions consistent with their financial arrangement and in keeping with a plans' expectations for performance.

Managed care has certainly spawned the progress in data acquisition and management for health care delivery. However, this would not have been possible without the progress in information collection and management made available by the proliferation of computer technology. When used properly, information on practice patterns is a powerful educational tool for physicians. Unfortunately, it is also being used as a bludgeon to herd practitioners toward managed care norms. It does not take long for physicians to learn that they must practice "by the numbers," concerned more for their statistics on utilization (e.g. lengths-of-stay, admissions per thousand, referral rates, etc.) than they may be for their complication rates. As teachers have long known: you get the results you can measure. Serious ethical questions arise when the measurements in turn are used to elicit results that are economically, rather than clinically, driven.

To compound this problem, the data used, by the industry's own admission, is often inadequate and maybe inaccurate. In the managed care text mentioned above, another "common problem" is identified as: "Failure to Track Correctly Medical Costs and Utilization." Within this section, the author notes that: "As growing plans develop problems with operations (the authorization system, claims, or data gathering in general), medical expense and utilization reports frequently suffer."[3] Despite this, aggregate and physician-specific data is being regularly used to direct care and impede independent decision-making by physicians. No one raises the obvious ethical concern: by changing the practices of physicians with these methods, inadequate and even erroneous data are used in ways that can result in serious harm to patients. Where are the consumer protections?

Finally, since most of the monitoring and profiling focuses on utilization and the resulting economic consequences, this information provides a rich resource for physician selection and deselection. This phenomenon, known as "economic credentialing," is often the basis upon which physician networks are formed. A leading managed care textbook warns about the "expense" involved directly and indirectly when a physician causes a plan to "lose on each member."[4] Plans cannot afford expensive physicians for any reason. Physicians who wish to be members of a managed care network, or wish to remain members, learn quickly that the plans have extensive utilization and financial information available from which they can make determinations about their continued ability to practice medicine. Those physicians who care for the neediest members of our society—women, some children, the aging, patients with chronic illnesses and other disabilities, the economically disadvantaged—suffer under such measurements. Plans want neither costly patients, nor the physicians who must care for them.

Intra-care processes

—Concurrent review for "continued stay" for hospitalized patients for earlier discharge

[3] Kongstvedt, p. 286.
[4] Kongstvedt, p. 287.

—Pre-admission authorization
—Shifting of some conditions from in-patient to out-patient requirements
—Length-of-stay assignment prior to admission
—Authorization for laboratory and diagnostic services
—Authorization for emergency room use
—Authorization for specialist referrals
—Primary care gatekeeper with limitation on access to other care
—Limitations of physician and facility networks
—Second opinion requirements
—"Medical necessity" determinations by plan
—Drug formularies with limitations on availability of certain pharmaceutical choices
—Manipulation of definitions to suit plan's needs, e.g. changing "skilled care" needs to "custodial care" needs

Intra-care processes arose as managed care plans moved to control the physician decision-making at the time care was in progress for a particular patient. Essentially there were two mechanisms by which this could be done: authorization structures and medical necessity determinations.

The authorization system is considered to be "one of the definitive elements" in managed health care.[5] This can range from a precertification of elective admissions in a "managed" indemnity plan and extend to the mandatory authorization of all nonprimary care services in an HMO.[5] Whatever the extent and structure for such authorizations, the purpose is to enable a plan to question a medical provider's decision regarding the care of the patient. This is most often done for "medical necessity." The plan, through use of its own criteria (rarely grounded in clinical studies, and even more rarely made public), holds itself (by way of its own doctors) as the point of final medical determination.

Whether through a gatekeeper system, or a structured system in which physicians must make each request for their patients, the result is the continuous, micromanagement of decisions regarding the care of a patient at hand. Physicians have varying responses to this:

—Some are intimidated easily into submission to the plan's requirements, easily done by physicians from a distance, often anonymous, and with unknown power over the practicing physician's professional future;
—Some physicians are "hassled" into submission, simply giving into plan's requirements because other patients and practice demands prevent them from battling it out with numerous individual patients and plans;
—Some physicians are rebellious and confrontational, but plans soon identify these physicians as "noncompliant," as noted above.

Whatever the response, eventually physicians understand that they do not practice medicine alone. Despite claims that a plan does not practice medicine, the final medical determination, as every plan states in their coverage booklet, is the prerogative of the plan. Medical reviewers and medical directors, employed or contracted by the plan, operating under no ethical codes for their hybrid positions, and monitored themselves by no one, make decisions based on little information, and from a distance, without ever seeing or touching the patients. Few physicians can afford, professionally or economically, to advocate for their patients against these decisions.

The power to influence decisions about care during the diagnosis and/or treatment phase is underestimated by the public. Strong financial concerns drive virtually every decision. Real quality and outcomes monitors are still too primitive and superficial to pick up the consequences of "medical necessity" determinations made for the best interest of the plan at the expense of the patient. In the meantime, physicians are increasingly walking a tightrope between allegiance to the system which makes it possible for them to practice and advocacy of the patients for whom they have primary responsibility. It should be no shock that more and more physicians are just accepting the medical criteria and decisions of the plans. To do otherwise is professional suicide. Meanwhile, the unsuspecting public continues to believe that their physician is their trusted advocate. Once again, the managed care industry banks on remnants from the fee-for-service system to achieve its surreptitious goal of physician control.

Pre-care processes

—Financial incentives/disincentives, through capitation, withholds, bonuses, penalty clauses;
—Practice profiling and targeting;

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[5] Kongstvedt, p. 182.

—Selection/deselection;
—Contractual conditions ("gag clauses") both explicit and implicit which prevent disclosure of financial arrangements, utilization management procedures, treatment options, structural limitations on referrals or available care; etc.;
—Contractual clauses to ensure compliance with plan's policies and procedures;
—Contractual clauses to prevent disparagement of a plan;
—Market penetration; and
—Unequal bargaining power.

Pre-care processes are those mechanisms by which professional decision-making is influenced and constrained so completely that a physician essentially becomes a "dual agent," with some other interest competing equally with any commitment to patients. In the worst cases, these other interests—a plan, success in the managed care market, professional viability, economic survival, etc.—become pre-eminent. The effect of "pre-care" controls is to change the very way a physician thinks before any patient enters his or her domain of care. If the physician begins to think as a "medical director" of the plan, then he or she will no longer need to have medical decisions overturned by another physician. The physician has "learned" to practice a new kind of medicine—that defined by the managed care plan or the industry as a whole.

Understanding this kind of management technique is critical to understanding the most evolved managed care plans. When the right conditions are created, the plan simply sets processes in motion. The treating physicians themselves do the "dirty work" of managed care. In the most sophisticated forms of this, plans have come full circle, appearing to give back "independence" to their physicians. However, such autonomy is elusive when the conditions have been designed to limit the range of "independence." A mouse in a maze has choices, but if there is no way out, freedom is reduced to exploring the impediments.

This is the most insidious form of management, for it involves eliminating the conditions which previously enabled a professional to remain independent and autonomous. The most effective payment arrangements and contract provisions are calculated to induce restrictions on resource use—a powerful, effective method to change the way a professional approaches the distribution of those resources. To argue that physicians continue to practice appropriately under such circumstances is essentially wishful thinking, for it ignores several critical facts:
—We know from the fee-for-service era that financial arrangements linked to quantity do effect what physicians decide;
—Physicians are equally susceptible to human forces of greed, self-interest, or just ordinary apathy as the rest of the population; and
—There are virtually no ways to identify or measure underutilization or inappropriate treatment currently.

Increasingly, physicians are simply the instruments for a philosophy and practice dictated by persons without training, license or permission to practice medicine.

AGGREGATE EFFECT OF THESE METHODS?

In this kind of environment, the practice of medicine becomes little more than a trade in which sophisticated means are used to manage job performance. Imagine the effect of all of the methods above as a physician attempts to do his or her work. This slowly erodes the professional's capacity to act independently, to use education and training for the benefit of his or her charges, and to continue to develop ways that accentuate clinical acumen. Although skill is important, there is some special dimension of the profession of medicine that makes a doctor more than just someone who services malfunctioning parts of a machine. A physician is a professional to the extent that he or she sees an illness as more than disease, infection, injury, or just numbers on a report. As a professional, a physician is granted the means to enter into a web of psychosocial relationships and responses to conditions of need.

Although medical ethicists explore in depth the autonomy of patients, there is little concern about the autonomy of the physician. A significant aspect of that autonomy derives from the ability to make independent decisions about how to treat. When a physician and a patient enter into a relationship, we need more than assurance of clinical competence. We need to know that a physician and a patient have a space conducive to care, compassion and choice. There must be mutual respect and trust by both parties. Self-interest of the physician (or interest by some other party) must not effect what occurs here. There must be confidentiality. There must be peace—or at least as few disturbances as possible. This means that we, as a society, must do the hard work of figuring out benefit and payment decisions before the emotionally laden events of need occur. Our goal should be to make it easy for physicians to be open, fair, compassionate, and caring—indeed to be the professionals

we train them to be—with every patient equally. We should provide uniform structures and operations to ensure that the health plan does not amplify existing fear, pain, suffering, anxiety and confusion.

Justice in health care means that there should be no financial, geographical or discriminatory barriers to levels of care that provide relief or care to any member of our society. If care is to be denied, particularly beneficial care, it should only be because resources will be better used elsewhere for other patient care. The determination of that should be open and explicit. Currently we do not have a system in which "cost-savings" from the "denial" of any services, however and whenever that occurs, can go back into the care of more people or more conditions.

With the combination of controls on all aspects of care, from post- to pre-care, we enter the most treacherous of management techniques: management by tight constraint and impediment. Is this the managed care goal—to have a physician who makes more by doing less; who suffers additional penalties for losses; who cannot divulge critical information to patients, including treatment alternatives or availability of specialty care; who will be profiled and credentialed for economic and utilization performance; who must comply with the plan's requirements for authorization and determinations of medical necessity; who risks sanctions, and possibly deselection, if contract provisions are violated; and who ultimately cannot express any negative comments about these conditions?

CONSEQUENCES TO PATIENT CARE

We are already deluged by patient stories. How many will it take?

Under such a subtle and obstructive management, the physician becomes essentially an agent of the plan or the society which is allowing these constraints to occur. Initially, the limitation or withholding of care could be supported by a genuine attempt to provide appropriate care. Gradually, reasons of self-interest, financial gain and assurance of professional future within managed care can begin to creep in. As troubling as this might be, there are more serious stages of concern. Empowered by the ability to grant or deny care, and rewarded financially when care is denied, a physician can easily slip into other reasons (consciously or unconsciously) to deny care based on personal, religious, and sociological factors. There is no perceptible line between denying care to someone because it incurs financial reward and denying care because spending the money is considered a "waste" for a particular type of patient or a specific condition of need.

CONSIDERATIONS FOR FUTURE REFORM

It is interesting that this phenomenon called "managed care" has developed and evolved with very little significant and effective ethical challenge. Serious questions must be answered:

—Are we willing to tolerate a system of access and resource allocation which depends upon constraints of professionals in order to achieve its results?

—If we object to the micromanagement of plans by the government, why do we allow, without examination, the micromanagement of physicians by managed care plans?

—If we believe that physicians must be scrutinized and controlled, then shouldn't the other health care professionals undergo the same degree of scrutiny and control?

—Are we really making cost-cutting changes for some "greater good"?

—Under what circumstances can an individual be harmed or even sacrificed for this "greater good"?

—Who defines this "greater good"?

—Is any "greater good" so great that it justifies ethical transgressions to achieve it?

A recent article in the Wall Street Journal posed this challenge: "Think of the health-care system as an airline that freezes ticket prices while inflation drives up the price of everything else. It makes a big difference how the airline has cut costs. If it is using aircraft more efficiently and firing underworked baggage handlers, customers will be pleased, even if baggage handlers aren't. But if the airline is avoiding maintenance and forcing pilots to fly without adequate rest, customers will be rightly worried."

We may be pillaging our most vital resource, changing dangerously the very system we each must rely upon as we age, as we care for our children, family members, friends, and neighbors. Let us hope that we have the willingness to understand and challenge the ethical assumptions made by managed care's management of this precious resource—our society's medical professionals.

Senator SPECTER. There is a large human cry in America today about what is happening in managed care. That is a subject I hear about most when I have open house meetings, which I do regularly, across Pennsylvania's 67 counties. It is beyond Pennsylvania. I heard about it a great deal last year as I traveled the country, but we need specifics. Of course, in this hearing today we are just beginning to scratch the surface.

Let me pick up on the gag rule with you, Dr. Nelson. As you properly note, there is a big difference between what is in writing, necessarily, and what is in practice. What is your judgment, if I may use that word, as contrasted with speculation?

Dr. NELSON. Well, sir, I think the——

Senator SPECTER. You are still an expert witness, and can get a case to the jury. So, what is your judgment?

Dr. NELSON. Interesting, I thought I was just a doctor. What happens is, of course, that there had been in the past, some very specific clauses to which you referred to initially, to be honest with you, through the Healthy American Association and others, many of those have been removed.

You are familiar earlier in the year with a couple of articles in Time magazine about care that was not to be allowed. One was the case of a Wilms tumor, a kidney tumor, in California, and one was a brain tumor of a child in New Jersey. We can get that information to you. The fact is that the clauses, per se——

Senator SPECTER. I would like that specific information.

Dr. NELSON. Yes, sir.

Senator SPECTER. Specifically, the clauses are being removed. The more subtle concern is how is the physician treated.

A particular case in point, a gynecologist, I am thinking of a case not long ago where a patient that I have known for a very long time needed, in her judgment and in my clinical opinion, to have her uterus removed, a hysterectomy.

The reason for which we did it was an obscure disease called adenomyosis, and that presents itself with pelvic pain. The patient was tremendously debilitated by her pain. A young woman with 6 children, who was very, very active.

A very long story made short is this patient was subjected to a whole bunch of things which I did not think were in her best interest, including: a GU, or a urologic evaluation; a gastrointestinal evaluation; a psychologic evaluation costing many hundreds of dollars and delaying her care for some time.

The point is that the practice of putting these hassles, these barriers, in my view in this case inappropriately is the larger issue, not just what is said in there. There are also some not so subtle things about not getting referrals from your other colleagues in the group if you do things a certain way that is not to the liking of the group. It is going to take a lot more digging, Senator, than just saying, "What is in the clause?"

Senator SPECTER. What is the best way to approach that?

What is the best way to approach that, Dr. Nelson? You represent the American Medical Association, a pretty big, powerful organization. How do we approach it to really get at the facts to know what we ought to be doing?

Dr. NELSON. We look at such things as Dr. Ware has done, look at the quality of care to see where these kinds of impediments are leading to the kinds of things that he has seen. As you saw, the research is only beginning, but a significant beginning, where we can document which care is being withheld for those kinds of reasons. We need to find ways to prevent that. I think we need to do the opposite as well.

We need to look where care is good, what are the good examples, where there is full disclosure, what kinds of plans are encouraging patients and physicians to talk in a way that is meaningful so they get better care, and not just look at the bad, but look at the good, and from that glean what we can to come up with the best way to go about it.

Senator SPECTER. Is the American Medical Association undertaking any study on this issue?

Dr. NELSON. Yes, sir; we are.

Senator SPECTER. What is it?

Dr. NELSON. We are looking at a couple of things. First of all, we can chronicle for you the concerns we have and the specific examples you have asked about the gag clause, per se.

We are undertaking an incredible deal, which is way too long to talk about. We hope to be able to accredit every physician who wishes to be on his or her own practice. We will look into five different areas, the credentials, his or her personal practices, the patients that they actually take care of, a site visit where they practice, and a chance for them to assess their own practice.

This will take some time to do. We are unveiling the first part of it in January. We think we will be able to accredit physicians who wish to have that done. By so doing, we hope to be able to identify best practices and have people practice in that way.

Senator SPECTER. Ms. Dallek, you commented about the need for HCFA to publish regulations. To the extent that you have any specific suggestions for this subcommittee, we would appreciate knowing them. We are going to be going into some depth on HCFA regulations. Do you think that a 6-year lapse between OBRA and a regulation on—the 6 year regulations between regulations and the stop loss protection might be a little excessive?

Ms. DALLEK. Yes; obviously, it was excessively long. In addition, I think it also took a long time to get these appeal provisions or regulations out. They are not out yet, but hopefully they will be out soon. I think there are a number of issues that we need to think about.

Perhaps, I think as Congress considers HMO legislation, they need to look to the States. There has been some very good and innovative things happening in New York and New Jersey, for example.

PATAKI in New York, providers, plans, consumers together, and really has fashioned a huge range of, I think, very significant legislation which everybody bought into—not happily obviously, but everybody bought into—that does a lot, I think, in terms of protecting enrollees, especially in terms of the access to specialty care.

New Jersey is coming out with some proposed regulations that will similarly protect folks. I think there is a lot that Congress

should think about in looking to the States. I did want to talk briefly about micromanaging, if I may.

I think that we did need and it was appropriate for Congress to come and to legislate in terms of the drive-thru deliveries. I think it was a concern of Americans and women around the country. However, I do agree with Dr. Wilensky that micromanaging is not the way to go because it just——

Senator SPECTER. OK. You draw us the line.

Ms. DALLEK. Well, I think the line needs to be drawn by setting processes for services. For example, if you can legislate in ways which say you have to have a great grievance system. If somebody says to you, to a woman, "You have got to get out of this. You had a mastectomy and we want you out the same day outpatient." The woman does not feel very comfortable with that. You have to have a system that will get an appeal and a response very quickly. We need a system where—the problem with HMO's is they are adopting these very rigid guidelines. Everybody has to be out of the hospital in 24 hours.

Senator SPECTER. How do you do that?

Ms. DALLEK. You have to have rules that say if you have a referral system, if you have a utilization review system, the physicians in the plans, the experts in the area, must be involved in setting these guidelines.

Senator SPECTER. OK. The woman is notified that she has had a mastectomy and she has got to be out that afternoon. There is an appeal process, presumably, within the HMO?

Ms. DALLEK. Or alternatively outside, expedited review outside. You can go to the State, go to a State complaint system. New Jersey is proposing an expedited review system outside of the HMO.

Senator SPECTER. The woman makes a call to a State official?

Ms. DALLEK. Yes; that is right. If you have a complaint system, you have ombudsman programs. There are a lot of processes. The ICA's, which Congress did not fund this year, but which HCFA did pick up funding, have been incredibly important for that Medicare population.

I mean, we have to think carefully about what to do, but I think that there are answers that are being developed, and that we can come up with some very good solutions and get together and find some common ground.

Senator SPECTER. You have been working in the field. Would you supplement your testimony by giving us your insights as to where you think HCFA ought to be publishing regulations and what you see on the appellant line, provide that to us in writing?

Ms. DALLEK. Sure. OK. That's fine.

Senator SPECTER. Dr. Margolis, I am very much impressed with the provider HMO's contrasted with others generally. Is the provider HMO in a little better position to avoid limitations on specialist referral, because they are all within the organization?

Dr. MARGOLIS. Senator, let me try to define a provider organization as opposed to a provider HMO. Provider organizations, at least the way the system works now, are in a position to contract with either one or multiple HMO's, usually multiple. One would be an exception such as in a defined system like Kaiser.

Within these multiple HMO's, if the provider system is large enough, integrated, and can incorporate primary care, specialty, teams of care, case manager, social workers, discharge planners, nurses, and the like, then it is in the position to become the accountable body for the kind of care that is being delivered.

Therefore, the providers now can bring the decisions back to where they belong, in my estimation; and that is, in informed discussion between doctors and patient. In response to the question you just asked Ms. Dallek, if I may?

Senator SPECTER. Please do.

Dr. MARGOLIS. I think the answer to this issue of mastectomy is full and informed discussion between the surgeon and the woman prior to a decision to have a mastectomy, not only what her options are clinically, but what her options are as far as outpatient, length of stay, and the like.

If there is an appeals necessary, it is because the physician and the patient did not come to a conclusion on what the best solution was. I think in that case you would mitigate against and minimize almost entirely this issue of post facto complaints about what kind of care was delivered and what the outcomes of that were.

Likewise, then on this issue of so-called micromanagement, until we can understand the outcomes of care that we are delivering and we can inform consumers, because we will be with Internet and other ways, in a position where consumers are in the position to be able to evaluate the outcomes of care, the complication rates, the quality of care, the average cost of care, and the like by provider organization, and by health plan.

Until we are in that position, we will not be able to have from a legislative point of view or any other point of view any kind of objective discussion about whether drive-thru deliveries is good or bad, whether mastectomies should be on the outpatient or inpatient basis.

I think that this embryonic science which Dr. Ware has helped to move forward, and which is under full steam in many, many organizations, is an appropriate place for you and your committee to help evaluate and appropriate appropriate resources to encourage the kind of outcomes research that will get us to the answers that we are all striving to get to.

Senator SPECTER. Dr. Margolis, with the provider HMO, is there less of an incentive for a specialist referral? Is there less than an incentive to discourage a specialist referral?

Dr. MARGOLIS. Again, I will speak to the large kinds of integrated multispecialty medical groups that AMGA represents. As I said, those are the largest and most well-known around the country.

When the measurement on how a provider is paid is based on an overall assessment of patient satisfaction, of access, of the quality of care as it can be measured usually through measures like the health plan employer data information set, described as HEDIS, and the like, that is how the provider is incentivized, not by whether he or she has some kind of pool of money that they may or may not get if they send it out.

Senator SPECTER. Well, how do you quantify that kind of provider incentive?

Dr. MARGOLIS. You establish an excellent information system and collect data from external objective evaluation of customer satisfaction from internal measures of access to care.

Senator SPECTER. How do you do that? A questionnaire?

Dr. MARGOLIS. On satisfaction, it is both by phone and questionnaire surveys; on access to care, it is actual——

Senator SPECTER. Does somebody make an evaluation as to how satisfied the patient is and determines the compensation?

Dr. MARGOLIS. Yes; correct. An outside, independent physician patient surveying organization. Many of them exist around the country at this point, and do that.

Senator SPECTER. Could you give us a little supplement on writing as to how that is done?

Dr. MARGOLIS. We will be happy to. On how in our organization and within AMGA we incentivize physicians or just on the patient satisfaction issue?

Senator SPECTER. Both.

Dr. MARGOLIS. Both. Yes, sir.

Senator SPECTER. Mr. MacBain, Geisinger is a unique kind of an operation, or maybe it is only unique because I know a little bit about it. You have an extraordinary health delivery system to rural Pennsylvania. Are there some aspects of Geisinger's organization that make you less susceptible to the kinds of problems we have heard about today: a gag rule, a limitation or referral to specialists, that sort of thing?

Mr. MACBAIN. Well, over the years we have developed a panel of independent physicians with whom we contract for members that is as large as our own medical group now, so we have——

Senator SPECTER. Essentially, a rural matter, though?

Mr. MACBAIN. Yes; rural, plus Scranton and Wilkes-Barre. We have a fair amount of experience. We certainly have never had anything in our contracts that would require a physician to withhold medical information from a patient. In fact, my own opinion is that, if anything, our patients are requiring more information, particularly in the last few years.

I know as a parent myself with two children with chronic illnesses, that fortunately are not severe, I am looking for more options. Do not just tell me what needs to be done, tell me what the options are. Generally, that is what we want our physicians to do.

Senator SPECTER. Is Geisinger, the Geisinger operation, a rural HMO, replicated significantly across the country?

Mr. MACBAIN. There are several, I think, based on large medical groups. It gives you a critical mass that you can build an HMO around.

Senator SPECTER. Are HMO's and their operation generally equally accessible in rural areas as in urban areas?

Mr. MACBAIN. Well, I think what an HMO does when you can make one available in a rural area is by linking the financing with the medical group and with a contractor delivery system is it lets you provide a guaranteed income to physicians in a way that will encourage them to locate practices in places where they might not if they were dependent upon the whims of fee-for-service medicine.

Now, that has not been extended as far as urban plans yet, but certainly we are discovering in Pennsylvania we now have an HMO

competitor in almost every county, so that other plans are beginning to move into rural areas now. It is good news.

Senator SPECTER. Dr. Nelson, you had a point that you wanted to make?

Dr. NELSON. Yes, sir; I am formally trained in quality improvement methodology and health care, and would point out that as the subcommittee looks at quality measurement, you do not just look at one part of it. You look at the entire spectrum.

Very briefly, it has to do with the issue of not only the patient satisfaction, which is very important, and the cost effectiveness which is important, but also the medical outcome, was the correct thing done.

A simple example to show you how wide this can vary. In the State of Utah, there are 54 hospitals that deliver babies. The caesarean delivery rate varies from 3 percent to 30 percent. Well, that is way too high a variation, so we have got to figure out what care goes where.

I received a letter the other day dinging me for my caesarean section rate being too high, something I prided myself on for a long time. Indeed, the numbers were correct. I had 13 patients in this particular plan, and I had done three caesarean sections. My rate was 23 percent, which was abhorrent.

I called the plan director and said, "My goodness, can you tell me which of these caesarean sections I should not have done? I want to learn; I want to be a good physician."

The answer was, "No, we cannot go into that kind of detail."

I was very concerned about that, so I went to the hospital where I practice, a large hospital, a tertiary hospital, one of the best in the country, in fact, the only one ever to receive the Balridge Award for Excellence, and found that my caesarean section rate was 8 percent. The lowest on the staff, by the way.

We have to be very careful what we look at, that we just do not get microcosms of this or that. Also, I would also point out again, Senator, the idea of looking at the good systems. One of our HMO groups that we work in, at our little hospital, we save three-quarters, because we did it correctly. Let us make sure we look at the good as well as those that are not.

Senator SPECTER. Well, we thank you very much for coming. We are just beginning to scratch the surface of this subject. We are in recess or more members of the subcommittee would have been here. We have a lot of work to do on health care as we look to the 105th Congress. We wanted to get a running start. There will be other hearings on this subject. I think this is going to be a major focus of attention. There were a number of groups and organizations requesting to give testimony at this hearing; but due to time limitations, we have asked that they submit statements for inclusion in the record.

CONCLUSION OF HEARING

I want to acknowledge on behalf of the subcommittee appreciation for the written testimony of the Blue Cross-Blue Shield Association showing a very strong interest in this hearing. We will keep the hearing record open for the next 2 weeks, and we will include

additional statements. We thank you very much for coming, and we will all stay tuned.

[Whereupon, at 1:10 p.m., Wednesday, November 13, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

Material Submitted Subsequent to Conclusion of Hearing

LETTER FROM MARY NELL LEHNHARD

BLUE CROSS BLUE SHIELD ASSOCIATION
Washington, DC, November 18, 1996.

Hon. ARLEN SPECTER,
U.S. Senate,
Washington DC.

DEAR SENATOR SPECTER: The Blue Cross and Blue Shield Association requests that the two attached papers be included in the record for your November 13 hearing on Safeguarding Seniors Health Care: Quality in Managed Care.

Blue Cross and Blue Shield Plans are the nation's leaders in managed health care. The Blues serve more than 33 million customers through HMO's, PPO's, Point-of-Service plans or other managed care arrangements.

Managed health care offers the potential to reduce rising health care expenditures while promoting high-quality care and strengthening the doctor-patient relationship. Blue Cross and Blue Shield managed health care programs seek to reduce costs while maintaining high quality through: selective health care networks; technology assessment; continuous quality improvement; streamlining administration; and anti-fraud programs.

The first paper attached is a Blue Cross Blue Shield Association news release regarding a study by American Viewpoint finding that Medicare beneficiaries with chronic illness and serious medical conditions prefer Health Maintenance Organizations (HMO's) over the traditional fee-for-service program for their care and treatment.

The survey also found that HMO members are more intensely satisfied than non-HMO members with the quality of their primary care physician. Survey respondents who had received their health care through the traditional Medicare program but had switched to an HMO cited a variety of reasons for preferring the HMO approach including: lower cost; more comprehensive coverage; convenience; high-quality service; the coordination of care and the quality of doctors.

The second document, Blue Cross and Blue Shield: The Natural Choice From Generation to Generation, highlights Blue Plans' leadership in health care management and innovation, especially our experience with managed care. HMO Blue Plans provide seniors with the highest quality of care, promoting preventive care, selecting the best doctors and hospitals, and creating special programs for people with chronic illnesses.

The document also discusses research demonstrating that HMO members are more likely to obtain mammograms, Pap smears, and other essential screenings than people in fee-for-service plans, and that HMOs' low co-payments encourage patients to see their doctors sooner.

We believe that both of these papers will be useful in understanding the important ways in which managed care ensures quality health services, and would be happy to testify at any future hearings on matters as important as safeguarding seniors' health care. Thank you for your attention to this issue.

Sincerely,

MARY NELL LEHNHARD.

[Blue Cross Blue Shield Association News Release, Sept. 20, 1995]

CHRONIC, SERIOUSLY ILL MEDICARE BENEFICIARIES PREFER HMO CARE OVER TRADITIONAL MEDICARE PROGRAM

WASHINGTON—A new nationwide survey reveals that Medicare beneficiaries with chronic illness and serious medical conditions prefer Health Maintenance Or-

ganizations (HMO's) over the traditional fee-for-service program for their care and treatment. The survey also found that these Medicare beneficiaries, by an overwhelming margin (89 percent), recommend that managed care should be a Medicare option.

The survey, released today by American Viewpoint, Inc. of Alexandria, Virginia, also found that, nationwide, Medicare beneficiaries enrolled in HMO's are significantly more satisfied with the health care and treatment they receive than are Medicare recipients who rely on fee-for-service arrangements.

"These findings offer solid evidence to dispel the myth that managed care is only effective in meeting the needs of healthy seniors," said Gary Ferguson, vice president of American Viewpoint.

The survey, conducted between August 17 and August 29, involved telephone interviews with 1,500 enrollees of Blue Cross and Blue Shield Medicare Risk HMO's and a comparable population of senior citizens in the traditional Medicare fee-for-service program.

According to the survey, senior citizens with chronic illnesses and serious medical conditions—including cancer, kidney disease, and pulmonary disease—who are HMO members are generally more satisfied with their current health coverage and medical care than those with the same conditions who receive their health care through the traditional Medicare program.

Significantly, 50 percent of the HMO members interviewed had experience with traditional Medicare before enrolling in their HMO. By a 3–1 margin, (60 percent-20 percent), these HMO members prefer their HMO's approach over their previous care. That margin holds true even with HMO enrollees with serious and chronic illnesses in 12 categories.

In addition, satisfaction with Blue Cross and Blue Shield Medicare Risk HMO's increased with length of enrollment.

Patrick G. Hays, President and Chief Executive Officer of the Blue Cross and Blue Shield Association, said, "As a number of studies have shown in the past, managed care has responded to private market needs for those under 65. This study lends proof that the same can happen for those over 65 as well. Congress should recognize the managed care industry as a high-quality, cost-effective and tremendously satisfying option for seniors."

"The Blues have had an unwavering commitment to senior citizens since the Medicare program began in 1965," he added. "We are proud that we have been there every step of the way as health care for seniors has improved over the years, and we will continue to be there as that care gets even better and managed care evolves to its full potential."

"These results are extremely encouraging," echoed Jake Hansen, Sr. Vice President of the Seniors Coalition. "With all the rhetoric floating around Washington about health costs, it is reassuring to know that seniors who suffer from these common but serious conditions can receive excellent health care from HMO's, and more importantly, that they are happy with the care they receive."

Survey respondents who had received their health care through the traditional Medicare program but had switched to an HMO cited a variety of reasons for preferring the HMO approach. These include: lower cost; more comprehensive coverage; convenience; high quality service; the coordination of care and the quality of doctors.

Among the survey's other significant findings:

Quality of care.—HMO members are as satisfied overall and more intensely satisfied than non-HMO members with the quality of their primary care physician. Among members, 93 percent are satisfied (81 percent very satisfied).

Among non-members, 93 percent also are satisfied; however, somewhat fewer (75 percent) are very satisfied.

Among members who suffer from the most serious and/or chronic diseases, 81 percent are very satisfied with the quality of their primary care physician, compared to only 75 percent of non-members.

HMO members are as satisfied and more intensely satisfied than non-HMO members with the quality of specialists. Among members, 80 percent are satisfied, with 69 percent intensely satisfied. Among non-members, 81 percent are satisfied with only 63 percent intensely satisfied.

Access to services.—HMO members and traditional Medicare enrollees rate access to the latest medical technology and tests similarly (76 percent and 79 percent). However, the intensity of satisfaction is higher among HMO members: 60 percent are very satisfied compared to only 53 percent of the traditional Medicare recipients.

As with other elements of their care, HMO members (81 percent) are as satisfied as traditional Medicare enrollees (84 percent) with their coordination of care between the different doctors they see. Among both members and non-members, satis-

faction increases as health declines. That is, the worse the individual's health becomes, the more satisfied they are with the way their health plan is coordinated.

As the Medicare program is reformed, Hays says, "Blue Cross and Blue Shield Plans will continue to advocate reforms that benefit our senior customers. We believe senior citizens should have access to the same high-quality, low cost options that are available to those Americans still working."

"We are both encouraged and motivated by these results," Hays added. "Encouraged by the success we've had serving our customers, and motivated by our pursuit of excellence."

A STUDY BY THE AMERICAN VIEWPOINT

OVERVIEW

The BlueCross BlueShield Association commissioned American Viewpoint, Inc., to conduct six focus groups with enrollees in Medicare Risk plans in Portland, Oregon, Miami, Florida, and Philadelphia, Pennsylvania. The groups were conducted on July 17, July 19, and August 1, respectively. The project was designed and conducted by Gary Ferguson, Vice President of American Viewpoint in conjunction with Chris Molineaux, Alixe Glen, and Mary Nell Lehnhard of the Association.

GOALS AND OBJECTIVES

The central purposes of the groups were as follows:

—To determine what enrollees in Medicare Risk plans like and dislike about their health plan and assess their willingness to recommend the plan to friends and family members, and the underlying reasons for those intentions.

—To provide Members of Congress with an effective tool for communicating with their constituents on the subject of Medicare managed care. In particular, to provide real-life stories that can be used to counter misinformation and scare tactics about managed care;

—To provide information to assist in marketing the BlueCross and BlueShield national Medicare risk product.

METHODOLOGY

All respondents were enrolled in a BlueCross or BlueShield Medicare Risk HMO. Length of membership ranged from 10 years to one month. Most respondents had been with their plan for at least a year. Respondents were selected randomly from lists of telephone numbers of enrollees provided by the plans. Members of the press and those under age 65 were not included in the study. No more than 50 percent of each group was aware of the Medicare trustees report. Respondents had a range of health conditions from excellent to poor.

These HMO's are fairly mature plans that have expanded as their rolls have increased. None is organized in the "classic" HMO definition in that none houses all plan doctors in one location. That is, respondents are able to go to physicians in individual offices in locations that are convenient to their homes. In Portland and Philadelphia, respondents report being able to choose from 400–500 physicians. In the three-county area covered by the "Medicare and More" plan in Miami, respondents say they have more than 1,000 doctors from which to choose. In all cases, numerous hospitals are available. Miami and Philadelphia have prescription drug plans while Portland does not. Many respondents report that their "family doctor" is on the list of doctors from which they are able to choose.

There are certain differences in coverage and out-of-pocket expenditures. In Oregon, enrollees pay $32 per month in premiums (with a $10 copayment) and have no prescription drug coverage; some dental coverage is included; they are entitled to an annual eye exam and a new eyeglass prescription every two years; the plan pays $80 on frames and $60 on lenses. In Miami, respondents pay no premiums, deductibles, or copayments and have prescription drug coverage and an eye plan similar to Oregon. In Philadelphia, enrollees pay no premiums and have prescription drug coverage. Those who are on individual plans pay $10 per prescription (30–90-day supply). Group enrollees pay half of the cost of prescriptions. All plans tested have no waiting period and no exclusions for preexisting conditions. About half of all respondents say they had fee-for-service Medicare prior to joining the HMO.

KEY FINDINGS

1. Seniors in HMO Medicare programs are extremely satisfied with their health care coverage. All respondents have what they consider to be comprehensive coverage. Even in Oregon, where prescription drug coverage is not part of the plan, they are extremely satisfied and feel they are getting a great deal for the money.

2. Respondents are very satisfied with the quality of their doctors and specialists.

3. Choice of physician in these particular plans is almost a non-issue. Respondents in all groups feel a wide range of choices is available to them and most respondents say their "family doctor" is one of the choices available to them and that there is an extensive list of physicians available to them both as primary care—physician and specialists. A wide choice of hospitals is also a major factor in the satisfaction of enrollees.

4. The BlueCross BlueShield name was an important factor in their decision to join their HMO and in their continued confidence in its financial stability and quality of care. Over and over, respondents voiced their confidence. As one man in Philadelphia says, "it's a name you can trust." No respondents mentioned any doubts about the financial solvency of their plan despite the existence of what they referred to as "fly by night HMO's."

5. Many respondents say they simply couldn't afford the kind of comprehensive health coverage they have if not for their membership in the HMO.

6. In all cases, but particularly in Miami and Philadelphia because of the high Medicare capitation rates, enrollees in BCBS Medicare HMO's have a far better deal than traditional Medicare recipients. In Portland, premiums are $32/month with a $10 co-pay as opposed to $70–$100 per month for a Medigap policy with equal benefits. In Philadelphia, there are no premiums or deductibles, but they have a copayment on prescriptions. In Miami, there are no monthly premiums, no deductibles, and no copayments.

7. Respondents feel they get as good or better care than other Medicare recipients. A big part of this is the preventive care ("preventive maintenance") approach HMO's take. Also, there is an acknowledged emphasis on wellness (advice on exercise, nutrition, partial payment on health club memberships, etc.). Finally, they feel that the quality of their physicians is no different than those available to traditional Medicare patients. In fact, many respondents say that the attitude of HMO physicians toward them is better than that of traditional doctors. Many respondents say that when they were on Medicare, doctors looked down on them. In the HMO, they feel their physicians exhibit a high level of interest in their well-being.

8. In all cases, enrollees are happy with the coordination of their care between the various doctors involved. In nearly every case, respondents say reports are called in or faxed between the various entities and that all participating physicians are up to date on their cases.

9. Respondents say they have never been denied treatments they thought were necessary. The most frequently cited drawback is the need to get referrals to see a specialist but even then, most respondents say that access to specialists is easily available. Other complaints include long waits in the doctor's office because the doctors have to see too many patients, that dealing with HMO administrative staff can be problematic, and that referrals outside of the plan are not covered.

10. Those who have had traditional Medicare are far more satisfied with their HMO than they were with Medicare. The reasons: less paperwork, lower cost, more extensive coverage, better care overall, better preventive medicine, and less waste, fraud and abuse.

11. Nearly all respondents say that they would recommend their plan to friends and relatives (and many have already done so). They definitely feel that the managed care option should be available to seniors nationwide and that it is a superior way of delivering health care.

12. Respondents are incredulous to learn of the low number of senior citizens nationwide who receive their health care through a managed care organization.

13. To overcome the objections of seniors who are reluctant to join a managed care approach, they would emphasize the lower out of pocket costs and the fact that paperwork is nearly non-existent; they say that even with extensive medical problems, they have never received a bill. They would also emphasize the choice of physicians that is available to them and the high quality of those physicians. Further, they mention the fact that if they are dissatisfied, they can change primary care physicians any time they wish.

14. There is still a great deal of skepticism about the impending bankruptcy of the Medicare trust fund. Their basic advice to Congressional leaders on reforming Medicare is as follows: "if they'd just keep their hands out of it, it would be all right;" "get rid of the waste, fraud and abuse;" and "cut Congress' perks and privileges." Others recommend encouraging seniors to join managed care plans.

GENERAL DISCUSSION

Most Important Factors In Decision To Join HMO

The most important factors in respondents' decision to join an HMO to receive their health care rather than using Medicare's traditional approach include: low cost, the BlueCross BlueShield name, past relationship with BlueCross and BlueShield, coverage, choice of doctors, choice of hospitals, experience ("I have friends who recommended it"), their doctor's recommendation, and the absence of paperwork.

Respondents took a variety of approaches to gathering information prior to their decision to join. Some attended seminars sponsored by the HMO, some read newspaper articles comparing the various plans in the area or read literature provided by the plans, some talked to their doctors, and others asked friends and relatives who are members about their HMO experience.

Breadth of Coverage

Although a great deal of emphasis has been placed on adding services and providing additional benefits in order to encourage Medicare recipients to join a managed care program, HMO seniors in Portland are highly satisfied with their program despite the fact that they have no prescription drug coverage, no full dental coverage, and a two-year restriction on new prescriptions for eyeglasses. They feel they have very comprehensive coverage despite the fact that they do not have the type of "full" coverage many people associate with HMO's.

As one man puts it: "I look at it like this. I have First Choice 65 and I'm 100 percent satisfied with it. But if you're going to go get dental and you're going to get eye and you're gonna get this and you're gonna get that your premium is going to go up. It's got to. For the basic rate that I pay, they cannot afford to cover me or my wife under it. For $33 bucks a month and a $10 copayment, and with that kind of payment you can't get any other insurance that cheap."

Another Oregon man says "The reason I got into this was my mother in law went into the hospital about three years ago with a heart problem; they put a pacemaker in and she was ready to go home when she had another attack; they had open-heart surgery and she was in intensive care for about three days * * * there was not a penny that anybody had to pay on that bill. If you start talking about this nickel and dime stuff, you'd better think about the $40,000 it would have cost her."

The most important factors in respondents' satisfaction in all cities are as follows:

High quality care.—Respondents are pleased with the quality of care they receive. Essentially, they say the quality of the doctors and nurses is as good as you would find anywhere. "It is no different than the care you would find anywhere." "There's no difference. My doctor is in private practice." In all groups, most respondents say that doctors, rather than physicians assistants, are their primary care givers.

One Florida man tells this story. "It's been a couple of years since I've been with Health Options * * * I had some heavy duty surgery that was adequately taken care of. And I mean heavy duty * * * a triple-A * * * an aneurism on your aorta * * * which was done very well (my doctor) referred me to a prominent surgeon. And I'm totally happy with it. All my needs are taken care of. I had a pacemaker put in which was done quite well * * * I had a hospital bill of $90,000 that was taken care of."

A Philadelphia woman says "They cover everything. I mean everything. My husband has been sick since the first of the year * * * he's had every kind of test in this whole world * * * he was in the hospital for an operation on his back, when he came home they had a visiting nurse there every day no problem * * *. He had a top surgeon for his surgery * * * we had supplies, a hospital bed, a walker, a visiting nurse every day * * * they sent technicians, everything * * * I can't say enough so any time they want a recommendation you've got my name for free, plastered all over every place because it is the best in the whole world."

Another man says "I've had knee replacements, I've had kidney problems, I've had cataracts, everything done under Health Options and I have absolutely no complaints. Everything has been taken care of just beautifully."

A Florida woman echoes this sentiment. "My husband had Parkinson's Disease, Paget's disease, and cancer of the lung. He'd been sick for many years and I have no complaints. He had good care when he was in the hospital and good care in the home also * * * I can say only good things about the HMO and we could well afford to do otherwise."

BLUE CROSS AND BLUE SHIELD: THE NATURAL CHOICE FROM GENERATION TO GENERATION

Over the past six decades, the nation's 63 independent, community-based Blue Cross and Blue Shield Plans have built a solid foundation of experience in providing consumers access to high-quality health care. By establishing national networks of doctors and hospitals; emphasizing preventive care and wellness; and using technology to streamline claims administration, Blue Plans have provided unmatched health security for millions of Americans. This tradition of excellence is rooted in a philosophy of continuous quality improvement. Blue Cross and Blue Shield Plans are constantly changing to meet customer needs. In fact, the Blues have consistently led the way toward new trends in health care management and innovation.

Although many Americans associate the Blue Cross and Blue Shield with their parents' or grandparents' health care coverage, today's Blues are at the forefront of providing high-quality, affordable managed health care. Enrollment in Blue managed care plans has grown an astounding 400 percent since 1985, surpassing membership in the traditional giant Kaiser Permanente. More than 30 million Blue Cross and Blue Shield customers—some 47 percent of total enrollment—are members of HMO's, PPO's or other managed care arrangements, and their numbers are growing daily. Moreover, the Blues collectively contract with 85 percent of the nation's hospitals and 75 percent of the nation's doctors. Whether rural, urban or suburban, literally every square inch of the United States is covered by a Blue Plan.

This unmatched size and scope makes the Blues the natural choice for people over 50. As the "Baby Boom" generation approaches retirement, the entire health care industry is repositioning itself to respond to changing customer needs—and once again, the Blues are leading the way.

AMERICA'S MEDICARE MANAGED CARE LEADER

Blue Plans offer the full range of Medicare coverage products, from traditional "Medigap" supplement policies to Medicare qualified HMO's. The Blues' unparalleled reach allows Blue Plans to tailor their coverage offerings to the specific needs of individual regions, states and communities. In addition, the Blues' unique national HMO network can provide health services to seniors in convenient, easily accessible locations—even for seniors who travel or maintain residences in more than one state.

The Blues' national presence and years of experience create distinct advantages for Medicare-eligible seniors who choose Blue coverage. Indeed, the Blues' infrastructure provided the very foundation for the original Medicare program. The Blue Cross system began providing Americans hospital coverage in 1929; the Blue Shield system of "service bureaus" for physician payment was launched in 1917.

Through the years, Blue Plans' national breadth has made them experts in successfully administering large, customized contracts. Blue Cross and Blue Shield Plans now cover more than 34 million Americans as intermediaries for Medicare, Medicaid and the Civilian Health and Medical Program of the Uniformed Services. No other carrier processes as many Medicare claims—85 percent of all Part A claims and 68 percent of all Part B claims. Moreover, the Blues process more than three-quarters of these claims electronically—which improves efficiency, lowers costs and reduces the turnaround time for beneficiaries. A unique computer network of 32 Blue Plans and 47 other payers provides additional efficiency in the commercial market. All of this adds up to the lowest administrative costs in the entire health industry—about one-third lower than competitors'.

Blue Cross and Blue Shield Plans are also fighting Medicare waste, fraud and abuse to help make the program more affordable and fair. The Blues' efforts are producing savings for the government and beneficiaries alike. In 1994, for example, stepped-up anti-fraud activities netted more than $68 million in recoveries and savings—a more than four-fold increase over the year before.

Geographic reach and administrative efficiency are not the Blues' only advantages in serving older Americans. The Blues' national Medicare HMO network, called Medicare Blue USA, provides unprecedented portable coverage for today's active, mobile seniors. By linking up Plan contractors throughout the nation, Medicare Blue USA allows its members to receive health services at any participating Plan in the nation—no matter how far from home they travel. While most HMO's cover out-of-area care only in emergencies, Medicare Blue USA offers the full range of health care benefits—even non-urgent or routine care.

In addition to making older Americans' health care more portable, Medicare Blue USA makes retiree health plans easier for employers to manage. A Medicare Blue USA network manager assumes many of the time-consuming administrative tasks involved in tracking HMO's in several locations. This national expert frees the indi-

vidual employer from premium billing, rate negotiation, performance reporting and other bureaucratic duties.

A NAME AMERICANS KNOW AND TRUST

Clearly, the Blues' unparalleled national networks, portability and administrative expertise make them the natural choice for Americans over 50. But perhaps the Blues' greatest advantage for seniors is the security of a Brand they know and trust. By the time most Americans reach retirement age, they have already had Blue Cross Blue Shield firsthand experience with the quality of Blue Cross and Blue Shield coverage. Their children and grandchildren were nurtured with Blue Cross and Blue Shield care.

Research demonstrates that the Blue Cross and Blue Shield are the most recognized and admired service marks in the health care industry. In fact, the Blues' Brand equity ranks with that of Coke and Pepsi. Moreover, the Blues are more familiar among seniors than any of the other Medicare HMO companies. In survey after survey, the Blues are consistently symbols of health care quality, efficiency and value.

QUALITY AND INNOVATION

A January 1996 General Accounting Office study found that Medicare beneficiaries who choose HMO's are attracted by three major advantages: Expanded benefits, reduced out-of-pocket costs and the ability to continue receiving health benefits provided by their former employers. Along with these important advantages, Blue Plans offer seniors additional assurance in the quality of care they receive. From promoting preventive care to selecting the best doctors and hospitals to creating special programs for people with chronic illnesses, quality and innovation are at the heart of the Blues' approach to managed health care.

Research shows that HMO members are more likely to obtain mammograms, Pap smears and other essential screenings than people in old-style, fee-for-service plans. Moreover, older Americans in HMO's who have cancer are diagnosed and treated earlier than seniors in traditional Medicare. Studies show that HMOs' low co-payments encourage patients to see their doctors sooner, rather than delaying care in order to avoid medical expenses. All this research proves what the Blues demonstrate each day: Managed health care improves not just the process of care delivery, but also its quality and outcome.

In this spirit of continuous quality improvement, Blue Plans offer a wide range of special programs for older Americans, including those with chronic illnesses. For instance, at Keystone Health Plan East, the HMO of Philadelphia-based Independence Blue Cross, doctors help Medicare HMO members consolidate their prescription drug use and reduce potentially dangerous interactions. Each new patient brings a brown bag with all his prescription drugs to his first doctor visit for an evaluation. Often, the doctor finds that several different doctors have unknowingly prescribed different medications that contraindicate the patient's other medicines—and could lead to catastrophic problems. A recent Harvard Medical School study found that these prescribing errors and other medication mistakes add $20 billion annually to the nation's health care tab. The Independence Blue Cross program helps reduce these costs while saving lives.

Blue Plans also offer special programs for patients with chronic illnesses such as asthma, diabetes, hypertension and congestive heart failure. These programs allow patients to monitor their own conditions at home, while checking in with a nurse every day. This personal nurse or "case manager" can also arrange for home visits, new equipment and even doctor house calls. This highly specialized, individualized care is impossible in the fragmented fee-for-service Medicare program.

The Blues' commitment to older Americans includes not only high-quality care today, but also research and technology that will provide innovative health care solutions for tomorrow. The Blue Cross and Blue Shield Technology Evaluation Center, for example, is the nation's leading publisher of technology assessment studies. TEC provides scientific analysis and opinions that help the Blues and other health plans determine which treatments best improve patients' health outcomes. More than 40 percent of insured Americans are covered through health plans that use TEC for technology assessment guidance. Moreover, TEC was one of the first systems of its kind to develop criteria for evaluating new treatments, medicines and procedures. These criteria, and the principles on which they are based, are now the industry leaders.

Blue Cross and Blue Shield Plans also sponsor a National Transplant Network designed to improve the quality and outcomes of organ transplantation. The network includes 40 Blue Plans and 51 nationally recognized hospitals in 26 states.

Each participating hospital must meet rigorous quality criteria developed by independent clinical experts. This network ensures that Blue patients who need organ transplants have access to America's most sophisticated treatment centers.

In addition to providing expertise in technology assessment and organ transplantation, the Blues offer a national medical management focus that promotes innovation throughout the 63 independent Plans. The National Council on Medical Management identifies best practices and promotes them throughout the system, helping to improve the quality of care provided to patients while enhancing physicians' knowledge and skills.

BEYOND TREATING ILLNESS—PROMOTING HEALTH

Blue Cross and Blue Shield Plans' commitment to quality expands beyond the traditional boundaries of acute medicine. The Blues are equally dedicated to preventive care that treats little problems early, before they become big ones. Moreover, Blue Plans are experts in promoting healthy lifestyles and wellness.

For example, Blue Plans routinely conduct "reminder campaigns" urging women over age 50 to obtain annual mammograms and to perform monthly breast self-examinations. Similar campaigns encourage patients to undergo Pap smears, cholesterol tests and influenza vaccines—which are particularly important for older Americans. Blue Plans also offer toll-free, 24-hour telephone advice programs to answer common health questions. In addition, the Blues provide their patients with a wealth of literature and classes to help them make healthier lifestyle choices. Topics range from smoking cessation and stress reduction to good nutrition and exercise to memory enhancement and self-protection against crime. Blue Plans also organize mall walking programs that promote fitness and social interaction in a fun, relaxed atmosphere.

The Blues often provide these necessary preventive services to their entire communities, not just their own members. In Pittsburgh, for instance, a mobile van brings mammograms into shopping malls, churches, senior centers and other convenient community locations. Similarly, the "Health CORNER" program provides registered nurses to 13 senior centers twice a month. More than 7000 people per year receive blood pressure screenings, wellness classes and the nurses' one-on-one advice through this program. In New Jersey, Plan members and non-members alike take advantage of free tests for cholesterol, blood pressure, eye diseases and other health indicators at the Plan's 12 health centers. Blue Plans also sponsor health fairs and festivals, as well as the Senior Olympics. Blue Plans even provide guest speakers on health topics for senior groups, churches, civic organizations, and television and radio programs.

A BOND WITH ALL OLDER AMERICANS

The Blue Cross and Blue Shield philosophy of health care includes not just preventing and treating illness—or even promoting healthy lifestyles—but creating healthier, safer, more vibrant communities. That's why Blue Plans support "Adopt-A-Neighborhood" programs that provide education, entertainment, home repair and social support for needy citizens. The Blues also collaborate with the National Council on Aging, as well as state and local aging agencies, to assist with home-delivered meals and other community services. The Blue commitment to healthy communities even includes support for the arts and cultural programs, such as the Garden State Arts Center Senior Concert Series in New Jersey.

Blue Cross and Blue Shield Plans also use their expertise in health care delivery to advise state and county officials on aging and disability issues. Most importantly, the Blues involve seniors themselves in expanding and enhancing community services. From Georgia to Kansas to Nebraska, for example, Blue Plans coordinate senior advisory councils to review Medicare customer services and combat fraud and abuse.

Similarly, Blue Plans participate in Medicare Beneficiary Liaison Councils to exchange ideas with consumers, government representatives, medical societies and other people interested in improving health care for older Americans. Blue Plans also conduct Medicare outreach seminars in senior centers, churches and provider sites to discuss eligibility, benefits, deductibles, coinsurance, claims processing and other issues that some new beneficiaries find confusing. Many Blue Plans offer similar workplace-based programs for people approaching retirement.

THE NATURAL CHOICE

The Blue Cross and Blue Shield commitment to Americans over age 50 is widely recognized. The Michigan Plan, for example, has been honored with the American Association of Retired Persons' Partners in Healthcare Award and the American So-

ciety on Aging Large Business Award, while the South Carolina Plan has received national accolades for its public awareness campaign against elder abuse.

But the most important tributes come from satisfied customers. A recent survey by the polling firm American Viewpoint found that only two percent of Blue Cross and Blue Shield Medicare HMO members would switch back to fee-for-service Medicare, even though they have the option of switching every month. That's a nearly unanimous vote of confidence in the Blues' Medicare HMO program. The survey also found that older Americans who have experienced both systems prefer their HMO's—by a three-to-one margin. This finding holds true even for seniors with serious, chronic illnesses such as cancer, kidney disease and pulmonary disease.

Blue Cross and Blue Shield Plans are drawing on their decades of experience to continuously improve the quality, efficiency and value of the health care they provide for more than 65 million Americans. As the nation's leaders in managed health care, Blue Plans are uniquely prepared to provide Americans over 50 with high-quality, affordable Medicare alternatives from a name they know and trust. The Blues' commitment to constantly striving for improvement—combined with their unparalleled geographic reach, administrative efficiency and dedication to quality and innovation—make Blue Cross and Blue Shield Plans the natural choice, from one generation to the next.

Prepared Statement of Josef J. Reum

My name is Josef J. Reum, and for more than 20 years I have served in state and local government supporting and providing social and health services to people with disabilities and our elderly citizens. I am here today representing The American Health Quality Association, which is a national membership association of organizations and individuals committed to community-based quality improvement. In September of this year I joined the association as its Executive Vice President. Quality Improvement Organizations (QIO's), formerly known as peer review organizations, and other health care improvement experts and organizations are members of the association.

Quality Improvement Organizations (QIO's) are community-based organizations promoting health care quality in all settings. QIO's improve the care provided to patients by monitoring health care patterns, identifying opportunities for improvement, interpreting and sharing information about care processes, health outcomes, and current science at the front lines of the health care delivery system. QIO's hold three-year contracts with the HCFA to evaluate the quality of care delivered to Medicare beneficiaries. They serve all 50 states, the District of Columbia, and the U.S. Territories. Additionally, QIO's work with state government and other purchasers of health care to evaluate and improve the quality of care delivered to various patient populations, in all settings.

We appreciate this opportunity to submit testimony to the Subcommittee.

Our purpose in providing testimony is two-fold. First, I would like to bring to your attention the existence of QIO's and their role in ensuring quality of care delivered particularly to Medicare beneficiaries in both the fee-for-service and managed care settings. This includes a discussion of AHQA's policy recommendations for a comprehensive quality assurance program for Medicare managed care. Second, we will share with you some examples of the importance of QIO's in regard to quality evaluation in managed care and fee-for-service delivery.

THE SHIFT TO MANAGED CARE

Over ten percent of the nation's Medicare population is enrolled in managed care plans, and Medicare enrollment in managed care plans has doubled in the past three years. So far, in 1996, beneficiaries have been enrolling in Medicare risk plans at a rate of almost 100,000 per month, and this dramatic rate of increase shows no signs of abating. Nationally, 74 percent of Medicare beneficiaries have a choice of two or more plans. While managed care enrollment varies greatly depending on geographic region, a majority of enrolled beneficiaries live in California, Florida, Oregon, New York, Arizona, and Hawaii.[1]

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[1] Health Care Financing Administration Planning Conference, Discussion Questions and Context Paper, May 14, 1996, pp. 15–16.

MEDICARE MANAGED CARE: A COMPREHENSIVE QUALITY ASSURANCE PROGRAM

Internal Quality Assurance and Improvement System

As a basic principle, managed care health plans should be responsible for ensuring and improving the quality of health care delivery to, and the health care outcomes of, their enrolled populations. To accomplish this, managed care health plans should establish internal comprehensive quality assurance and improvement systems that address plan performance, including the delivery and outcomes of care.

Currently, health maintenance organizations and competitive medical plans (HMO's/CMP's) contracting with Medicare are required to have an internal quality assessment and improvement program. An internal quality assessment and improvement program consists of the following parts:

—an ongoing program evidenced by a written plan describing the structure, responsibilities, types of activities, and specific quality improvement projects for the coming year;

—an approach that stresses health outcomes, covering the entire range of care provided, and that examines the effects of provider compensation and incentive arrangements to ensure that appropriate services are in fact provided;

—a systematic iterative process to identify problems and areas for improvement by making appropriate changes, and monitor changes over time for effectiveness;

—peer review by physicians and other health professionals of the processes of clinical care;

—systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners; and,

—written procedures for taking appropriate action to change areas needing improvement, and a process to determine overall effectiveness of the program and individual action plans.[2]

External Quality Assurance and Improvement System

Internal quality assurance systems are both necessary and important, but by themselves are incomplete and insufficient to meet the critical public need for assurance of high quality health care. Public accountability demands that internal health plan quality assurance and improvement systems be complemented by a dependable, reliable information system and an external analysis, verification and comparative improvement system.

External quality assurance mechanisms exist at different levels to meet a variety of needs. We envision external evaluation operating on three levels:

—The first level of external quality assurance is state licensing, federal certification, and voluntary accreditation. These processes assure that the most basic structural aspects of quality—such as proper credentialling of professionals and beneficiary grievance and appeals processes—and minimum standards for operating health care facilities are met. Licensing, certification and accreditation provide a level playing field and some degree of uniformity across all plan operations.

—The second component of an external quality evaluation system is an active, independent, community-based quality improvement program whose work goes beyond structure and process examinations of the first level to assess and to help improve access, clinical processes and health care outcomes. Functions of such a program should include data collection and analysis, feedback of clinical performance information, and, development of measures and initiatives that lead to improvements in access and in the quality of care provided by plans to enrollees and the surrounding community. It is important to note that this effort specifically addresses medical, surgical and other procedural treatments, identifying specific process and systemic improvements leading to improved patient care and health status.

—The third and final level of an external quality assurance system is a public information and reporting component. Such an information system is important for impartial and public reporting on health plan services, prices and performance in ways that will help both group purchasers and individual consumers in the selection of health plans, and stimulates fair and honest competition based on quality as well as cost.

This testimony offers two illustrations of the second component—an external quality improvement program—highlighted by the experiences of the Colorado and Ari-

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[2] Armstead, Rodney C., M.D., Elstein, Paul, Ph.D., and Gorman, John. "Toward a 21st Century Quality Measurement System for Managed-Care Organizations." Health are Financing Review. Summer 1995, Vol. 16, No. 4, pp. 25–37.

zona Quality Improvement Organizations (QIO's). These western states were selected from the total system of community based quality improvement efforts because they represent both urban and rural communities and they demonstrate two distinctly different models of how managed care has entered the marketplace.

OVERVIEW: QIO ROLE IN CARE EVALUATION

Today, QIO's are leading collaborative health care improvement projects with Medicare managed care risk contractors. Quality improvement efforts in managed care follow the same principles as in the fee-for-service environment, with the QIO and the plan jointly entering into quality improvement activities.

The QIOs' work is centered on identifying and promoting opportunities to improve medical care actually delivered. QIO's bring together managed care plans to implement ways to improve access to care, clinical processes and outcomes, and health status. Project topics range from access to care issues identified through beneficiary complaints; provision of preventive care, such as influenza immunization; improvement in care processes, such as follow-up after an abnormal mammogram, hypertension, treatment of heart disease; or surveys of patients' health statuses (diabetes), to name a few. Managed care plans derive many benefits from working with the QIO and each other. Among them are sharing of data and processes, benchmarking performance, and continually improving care. Cost savings and market differentiation are other benefits for participating plans.

The QIO experiences gained in Colorado and Arizona are significant in that the opportunity for continuous quality improvement, and its effect on the outcomes of care is readily apparent.

THE COLORADO MANAGED CARE EXPERIENCE

In Colorado, approximately 10 percent of the Colorado Medicare population are participating in managed care plans, while over 25 percent of the Colorado Medicaid population are participating in managed care plans. Statewide, almost 60 percent of the population are involved in managed care in Colorado.

CFMC began working with managed care plans in Colorado with Medicare risk contracts on a voluntary basis three and one-half years ago, with a quality improvement activity (or project) focusing on appropriate measurement and documentation of blood pressure in the outpatient setting. Implementation of individualized quality improvement plans at each of the four participating HMO's resulted in remeasurement evidence of clinical and statistical improvement. With this voluntary effort as the foundation, and with the further commitment of the managed care plans in Colorado, CFMC petitioned for and was granted a waiver from HCFA to perform other quality improvement projects (QIP's) in place of the implicit chart review then required by contract.

CFMC meets regularly with the quality improvement staff and physician representatives of all eight Medicare HMO's in Colorado to cooperatively select clinical practice areas to focus activities in the QI arena. Diabetes was selected as the ongoing, all participant project and is in the chart abstraction (clinical data collection) phase at this time.

Once a topic for improvement is conceptualized by the HMO quality managers and physicians, CFMC constitutes a collaborative study group for clinical content and direction, and an internal team to develop and implement the design of the QIP. Cooperative, consensus driven efforts by all participants have been achieved at all phases of project management—indicator development, design, chart selection, abstraction tool, analyses and dissemination, as well as remeasurement. Specifically, we are working with providers to identify the benchmark providers, how they accomplish these achievements, and what it has taken to implement these systems of care. Once known, we collaboratively share this information to let the managed care plans compete not on the attainment of knowledge, but the application of knowledge.

Current projects being developed include management of falls, vaccine use (influenza and pneumococcal), congestive heart failure (CHF), community acquired pneumonia (CAP), and, depression. One other outcome of these discussions has been active consideration by the managed care plan medical directors of sharing individual plan identities among themselves in each study to facilitate improvement learning and accelerate change.

SHARING AMONG QIO'S

Just as QIO's serve as a facilitating, collaborative partner across managed care plans, QIO's provide the same working relationship with their peers in other states. Enclosed as Attachment A is information from the Arizona QIO, Health Services

Advisory Group, Inc., which documents improvement efforts for diabetic disease management and efforts to increase immunizations.

Concerning the fee-for-service Medicare delivery system in Colorado, CFMC has enclosed as Attachment B a description of a number of our health care quality improvement projects, the rationale for these efforts, and customer comments about the value of our collaborative efforts to the health care system. Each of these studies is in the remeasurement stage and offers a significant opportunity to document improvement of care over the baseline period.

CONCLUSION

Information shared about two QIO's is reflective of the efforts in progress nationwide in health care quality improvement. Based on recent information from 37 states, there are over 850 HCQIP studies in process in both the fee-for-service and managed care delivery systems. The activities of QIO's help identify areas of improvement, develop and promote collaboration across hospitals and managed care plans, and serve the Medicare beneficiaries through evaluative and improvement efforts to enhance care delivered. The competitive health care system is not, by itself, creating these efforts, nor is it providing an ability to learn what differences exist within or between fee-for-service and managed care delivery.

The presence of an unbiased professional organization with the resources and dedication evidence by QIO's will become even more essential as the health care market matures. The lessons learned in Colorado, Arizona and other states are shared across the entire QIO community, making our efforts to improve care available across the nation. The level of quality of care provided by managed care plans should be assured and ever improved with the QIO's continued involvement.

Again, we appreciate the opportunity to testify and look forward to working with the PPRC on designing strategies for improvement of the quality of health care Medicare beneficiaries and all Americans.

ATTACHMENT A

THE ARIZONA EXPERIENCE

The Arizona Diabetes Pilot: A Case Study in Disease Management

In late 1993, HCFA asked the QIO's to suggest quality evaluation programs for managed care. In early 1994, we submitted a proposal which was accepted by HCFA that allowed the Health Services Advisory Group, Inc. (HSAG) to conduct a pilot quality improvement program in collaboration with the (then only) six Arizona Medicare managed care plans. Rather than perform a random sampling of managed care patients, we agreed to review records of randomly selected diabetic patients from each plan. Patients were identified by the plans.

Diabetes was chosen because of the significant frequency of this condition among the Medicare population and the high correlation between the illness and the use of hospital services. The choice was uniformly accepted by all participants. The directors of the six managed care plans, as well as experts chosen by the plans and HSAG, worked collaboratively to develop an agreed-upon appropriate method of treatment for patients with diabetes (i.e., specific criteria which ought to be used to determine the adequacy of disease management). Criteria were in keeping with the latest scientific studies.

HSAG reviewed the patients' medical records and determined how well the plans had adhered to the disease management criteria they themselves had determined were most appropriate for diabetes. HSAG then fed this information back to the plans, and showed them their specific adherence rates, as well as the aggregate rates, so that individual plans could know how they compared to each other. Each plan then developed a quality improvement plan to increase its compliance with the standards to which the group had agreed. Re-study of medical records at a later date provided the opportunity to gauge the effectiveness of each plan's efforts at quality improvement.

Appendix One illustrates the changes in physician and patient behavior.

Next Steps

Future efforts will allow measurement of the results of higher rates of compliance as should be manifested by lower rates of hospitalization and complications. The information gained in the Arizona diabetes project has been useful in other respects. It has allowed HSAG not only to catalyze improvements in the managed care setting, but also has afforded the opportunity to compare and contrast disease management in both the managed care and fee-for-service settings.

HSAG was pleased to learn that, in Arizona, there were no significant differences between the two care settings. Results indeed have suggested that care provided in managed care offers the possibility of being more responsive to quality improvement efforts. This was exemplified by a separate HSAG effort to increase the immunizations against influenza, where we saw little or no change in fee-for-service, but a marked increase of about 15 percent in managed care (comparing 1994 to 1995 data).

Appendix Two displays the data on this project.

Attachment B

IMPROVEMENT THROUGH INNOVATION

CFMC—HEALTH CARE QUALITY IMPROVEMENT PROJECTS

ACE Inhibitors in Diabetes.—Improve care in the screening and treatment of diabetic nephropathy (appropriate use of ACEI) in hospitalized diabetic patients.

Anticoagulation Management of Venous Thromboembolism (AMVT).—Improve usage or emerging drug therapy and continue education regarding management of drug therapy for anticoagulant management in patients with venous thromboembolism.

Aspirin and Thrombolytics Use in AMI for Rural Hospitals.—Analyze the appropriate and timely administration of thrombolytics and aspirin in patients with AMI, giving information to permit improvement of care in rural hospitals.

Breast Cancer Telesurvey.—Conduct a telephone survey of breast cancer patients to obtain direct patient feedback to improve quality of life and the treatment decision processes for these patients.

Breast Conserving Therapy.—Improve the method for addressing treatment options among Medicare beneficiaries diagnosed with breast cancer.

Cancer Care in Colorado.—Analyze treatment patterns given to cancer patients to improve the quality of cancer care in Colorado.

Congestive Heart Failure.—Improve the diagnosis and treatment of Congestive Heart Failure in the Medicare population.

Cooperative Cardiovascular Project (CCP).—Improve the quality of care provided to Medicare beneficiaries diagnosed with Acute Myocardioal Infarctions (AMI).

HMO Diabetes.—Decrease the rate of long term complications of Diabetes through prevention care and early monitoring by working to improve physician practice patterns in an outpatient setting.

Influenza/Pneumococcal/TB (IPTB).—Improve the rates of immunization for Flu, improve immunization rates for Pneumonia and increase screening rates for TB among statewide nursing homes.

Peptic Ulcer Disease (PUD).—Improve treatment patterns among patients with Peptic Ulcer Disease by screening for H. pylori.

Restraints in Nursing Homes.—Improve the quality of nursing home resident life by standardizing the use of restraints.

Transfusions.—Improve red blood cell transfusion practices in elective surgeries and compare post-operative infection rates based upon blood source.

THE USE OF ACE INHIBITORS IN DIABETIC NEPHROPATHY

Background.—Over time, many diabetic patients develop nephropathy, especially if other parameters such as hypertension and hyperglycemia are not controlled. An inpatient hospital stay creates an excellent opportunity to screen the diabetic patient for nephropathy. If nephropathy is present, treatment with angiotensin-converting enzyme (ACE) inhibitors significantly slows progression of end stage renal disease.

Purpose.—Assess the rate of screening for diabetic nephropaths during an inpatient hospitalization. Assess the rate of appropriate ACE inhibitor use for patients with mild to moderate diabetic nephropathy.

Methodology.—The statewide sample consists of 600 Medicare beneficiaries who were hospitalized January through December 1993. The study excluded transplant and dialysis patients.

Findings.—Appropriate urinalysis screening of diabetic patients was done on 68 percent of the studied patients. In cases where ACE inhibitor treatment was indicated, only 34 percent received ACE inhibitors on discharge.

There is a significant opportunity to improve treatment of patients facing diabetic nephropathy through the appropriate use of ACE inhibitors.

Provider Feedback.—Baseline results were disseminated in written format to hospitals statewide in July 1995. Project presentations were initiated with physicians, house staff, diabetes teams, and a Pharmacy and Therapeutic Committee. A CME video on diabetes management is available for review.

Follow-up.—A remeasurement to baseline data is in progress and is expected to demonstrate significant improvement in the screening for diabetic nephropathy and the appropriate use of ACE inhibitors.

Contact.—Thomas Dunn, M.D., clinical coordinator, and Laura Palmer, team leader, Denver CO. Phone (303) 695–3300.

CONGESTIVE HEART FAILURE—PUTTING THE PIECES TOGETHER * * *

Background.—In June 1994, AHCPR published clinical practice guidelines for the evaluation and care of patients with left-ventricular systolic dysfunction.[3] These guidelines address numerous facets of care including evaluation of LV function, use of ACE Inhibitor therapy, and several discharge instruction indicators.

Purpose.—This CHF Project was designed to measure the following quality indicators: Initial Evaluation of Left Ventricular Function; Use of ACE Inhibitors for patients with EF $\leqq$ 40 percent, in the absence of specific contraindications.

Methodology.—Seven Colorado hospitals collaborated on this project. One thousand one hundred and twenty-six cases were selected from the collaborating hospitals, based upon a principal diagnosis of CHF. These records were reviewed for confirmation of the CHF diagnosis and to measure performance as compared to the selected quality indicators.

Opportunities to Improve Care.—Approximately one-half to two-thirds of CHF patients with confirmed left ventricular dysfunction were not discharged on ACE Inhibitor therapy. Patients with presumed left ventricular dysfunction, not confirmed by diagnostic test, were discharged on ACE Inhibitors 20 percent of the time.

Follow-up.—Disseminated findings to provider community in October 1996; Share project information with Colorado medical community; Provide an audiotape of expert discussion defining recognition and treatment of CHF; Offer CME credit with CHF audiotape; and Repeat data collection once improvement plans have been implemented.

Contact.—Fredrick Abrams, M.D., clinical coordinator, and Debbie Ralston, project team manager, Denver, CO. Phone (303) 695–3300.

HMO DIABETES PROJECT

Background.—The Health Maintenance Organization (HMO) Documentation of Blood Pressure study, conducted by CFMC, is a Health Care Quality Improvement Project (HCQIP). CFMC and Medicare Risk HMO providers of Colorado explored the possibility of pursuing collaborative improvement projects and expanding HCQIP projects into the HMO arena.

Diabetes Mellitus is a chronic illness with the potential of significant socioeconomic impact. Findings from the Diabetes Control and Complications Trial proved that tight glycemic control and quality health care substantially reduce microvascular complications associated with diabetes. Given the complexities of coordinating patient care among various primary care providers and specialists, patients with health care needs that involve many organ systems may not always receive appropriate care.

Purpose.—The HMO Diabetes Project Team and the HMO Study Group developed the following objectives: Increase compliance rates with the American Diabetic Association guidelines for care; Improve physician practice patterns in outpatient care for Diabetic Medicare patients; Decrease the rate of long-term complications of Diabetes Mellitus through prevention care and early monitoring.

Methodology.—The study sample includes 368 Medicare beneficiaries (aged 65 and older as of 12/31/95) who were members of a Medicare-Risk HMO plan for the calendar year 1995, with no more than a 45-day lapse of coverage within that year, and who are receiving insulin and/or oral hypoglycemics per pharmacy records.

Opportunities to Improve Care.—Guidelines developed by the ADA and published in 1989 outline the diverse medical needs of diabetic patients. Adherence to ADA guidelines are contingent on many factors, including patient and physician compliance. In some clinical settings, both patients and physicians find difficulty in complying with all of the guidelines. By measuring the adherence to ADA guidelines within a health care delivery system, providers have the opportunity to improve the

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[3] Heart Failure Evaluation and Care of Patients With Left-Ventricular Dysfunction. Clinical Practice guideline Number 11 AHCPR Publication No. 94–0612. Rockville, MD. AHCPR/NHLBI, PHS, DHHS. June 1994.

quality of health care among patients with Diabetes Mellitus, Health Maintenance Organizations are in a unique position to monitor and assess the care received by diabetic members. Moreover, they are in a situation to implement educational programs about Diabetes Mellitus for physicians and patients.

Contact.—Thomas Dunn, M.D., clinical coordinator, and Melanie Herrera Bortz, MPA, project team leader, Denver, CO. Phone (303) 695–3300.

INFLUENZA, PNEUMOCOCCAL AND TB SURVEILLANCE IN COLORADO LONG TERM CARE FACILITIES

Background.—Eight million new cases of TB occur each year world-wide. Twenty-two thousand of these are reported in the United States. Thousands of people die each year from influenza-related illnesses. Most deaths caused by influenza are in people over age 65. The pneumococcal vaccine prevents more than just pneumonia. Anyone 65 or older and anyone with a chronic illness should get the pneumococcal vaccine.

Purpose.—To provide Colorado Nursing facilities with a method of educating staff, residents, and residents' families about the availability and importance of preventative measures against Influenza and Pneumococcal and to encourage consistent screenings for TB. To assess current immunization rates in Colorado Nursing Homes. To compare immunization and screening rates in facilities with policies to those without policies. To assess the impact of Medical Directors' views on immunization and screening rates. To exceed the Healthy People 2000 goal of immunizing 80 percent of all Long Term Care residents.

Methodology.—CFMC conducted a three-part data collection to assess the rates of Influenza and Pneumococcal Vaccinations and TB surveillance in long term care facilities throughout Colorado.

—Information was obtained from long term care facilities regarding their policies for immunizations and surveillance.

—Medical Directors of long-term care facilities were asked about their perceptions regarding the importance of immunizations and surveillance.

—Information was collected about the actual experience of 1,215 long-term care residents in regard to immunizations and surveillance.

Opportunities to Improve Care.—22 percent of our nursing home resident sample had a pneumococcal vaccine documented in their record. 61 percent of our nursing home resident sample had a documented TB screen. 83 percent of our 1,215 resident sample had a documented Influenza vaccine. 51 percent of facilities have a policy regarding pneumococcal vaccination. Medical Directors did not perceive the importance of influenza and pneumococcal vaccinations for long-term care facility residents. And the presence of a policy seems to improve the rate of pneumococcal immunization.

Contact.—Thomas Dunn, M.D., clinical director, and Debbie Ralston, project team manager, Denver, CO. Phone (303) 695–3300.

HELICOBACTER PYLORI IN PEPTIC ULCER DISEASE

A Health Care Quality Improvement Project.—Peptic ulcer disease is associated with significant, recurrent and chronic disability, as well as expensive maintenance drug therapy. In the 1980's, with the discovery of Helicobacter pylori (H. pylori) infection and its relationship to peptic ulcer disease, treatment for peptic ulcer disease has changed dramatically. In addition, nonsteroidal anti-inflammatory drug (NSAID) use is a large factor in ulcers in the Medicare population. This project is the multi-state effort of five PRO's, including Colorado, Connecticut, Oklahoma, Georgia, and Virginia, in conjunction with the Kerr L. White Institute. (CFMC serves as the lead PRO on this project.)

Findings.—Fifty-four percent with principal diagnosis of Peptic Ulcer Disease were screened for H. pylori; 86 percent with a biopsy performed received a tissue test (urease, culture or histology) for H. pylori; 75 percent with positive results on H. pylori screen were treated for H. pylori; 83 percent of patients were screened for pre-admission NSAID use; 28 percent were counseled about NSAID use. 4 percent were counseled about the ulcer risk associated with NSAID use; and 27 percent were treated for H. pylori empirically (without tests).

Study Aids.—The Helicobacter Pylori in Peptic Ulcer Disease project aims to assess statewide and inter-state variations: in methods and freguency of diagnosing H. pylori infections in Medicare inpatients; in the proportion of Medicare inpatients with ulcers of the stomach and duodenum and H. pylori infections who receive appropriate drug therapy to eradicate H. pylori; and in the proportion of Medicare patients with peptic ulcers who receive screening for and counseling about the use of NSAID's.

Study Design.—The baseline information is from a statewide random sample of Medicare discharges with a principle diagnosis of peptic ulcer, during the period of January 1995 through June]995. The sample consists of 550 medical records from each collaborating state.

Opportunities to Improve Care.—A 46 percent opportunity to improve health care by screening for H. pylori in ulcer patients in Colorado hospitals. Substantial opportunities exist to improve counseling in the risks of ulcers by NSAID use.

Assessing Effectiveness.—After providers have an opportunity to implement improvement plans, CFMC will remeasure hospitals' success in the improvement of screening and treating H. pylori in ulcer-risk patients.

Contact.—William Alexander, M.D., clinical coordinator, and Michelle Mills, project team leader, Denver, CO. Phone (303) 695–3300.

RBC TRANSFUSIONS IN ELECTIVE SURGERY

Background.—Health Care Financing Administration (HCFA) directed PRO's to initiate a quality improvement project addressing the appropriate use of RBC transfusions. PRO members of the Kerr L. White Institute collaborated to implement this multi-state transfusion project (CO, GA, OK, VA and CT).

Purpose.—To improve RBC transfusion practices based upon the recommendations of the American College of Physicians (ACP).[4] To compare post-operative infection rates of all patients based upon blood source.

Methodology.—Four Colorado urban hospitals collaborated on this project. Three elective surgical procedures were targeted: total knee replacement, total hip replacement, and hysterectomy. Five hundred and thirty-nine Colorado records, representing 471 transfusions, were evaluated. Additional data were analyzed from hospital blood banks.

Findings.—Post-operatively: 38 percent of the transfusions administered met the ACP guidelines. Modified ACP guidelines (eliminating the crystalloid/colloid criteria) analysis indicates 24 percent of the transfusions were appropriately administered.

Intra-operatively.—The appropriateness of these transfusions could not be determined. Wound infection rates were higher for patients receiving homologous transfusions as compared to patients receiving autologous transfusions.

Follow-up.—Collaborating providers are currently developing improvement plans to improve ACP guideline compliance. Remeasurement will be conducted after implementation of improvement plans, tentatively targeted for early 1997.

Contact.—William Alexander, M.D., clinical coordinator and Melanie Herrera Bortz, M.P.A., team leader, Denver, CO. Phone (303) 695–3300.

WHY WE CHOOSE WHAT WE DO

CFMC, in partnership with HCFA and collaborators throughout Colorado's health care community, dedicates significant time and resources to identifying those areas of health care which have the highest potential for impacting treatment. It is CFMC's vision to innovatively lead and facilitate health care quality improvement efforts as we move into the 21st Century.

SLOWING THE PROGRESSION OF KIDNEY DISEASE IN DIABETIC PATIENTS

The October 1996 issue of the Diabetes Care Journal noted that up to 40 percent of the 14 million people with diabetes in the United States will develop kidney disease.

In 1990, 200,000 people in the U.S. had end stage renal disease (serious kidney damage) resulting in direct medical and related expenditures of $7.3 billion dollars.

In 1990 alone, diabetic patients with end stage renal disease consumed more than 10 times the health care resources as the average citizen.

Treatment with ACE inhibitors was found to have a savings of up to $84,000 per patient over the course of a lifetime, as compared to treatment with a placebo.

The present value of cumulative health care costs in the United States, if diabetic patients were appropriately prescribed ACE inhibitors for a 10-year period, would be $2.4 billion dollars.

CFMC's ACE Inhibitors in Diabetes project is a quality improvement effort to increase appropriate use of ACE Inhibitors in the diabetic patient.

CFMC is collaborating with the health care community in both hospital and outpatient populations. As a result of this educational and quality improvement effort,

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[4] Goodnough LT. Meenan KR. Welch HG. Prudent strategies for elective red blood cell transfusion. Annual Internal Medicine 1992:116 393–402. Audet AM, Goodnough LT. Practice strategies for elective red blood cell transfusion. Annual Internal Medicine 1992:116 403–406.

CFMC has the potential to significantly impact expenditure of health care dollars while improving patient care and outcome.

CONGESTIVE HEART FAILURE

One-year mortality rates for patients suffering from Congestive Heart Failure (CHF) are in the range of 10 percent. Five-year mortality rates are in the range of 50 percent.

In 1993, The National Heart, Lung, and Blood Institute (NHLBI) estimated that nearly 4 million Americans are afflicted with heart failure.

The NHLB estimated that there are 400,000 new cases of CHF diagnosed each year.

Landmark trials published over the last decade have demonstrated that the addition of Angiotensin-Converting Enzyme Inhibitors (ACEI) to conventional therapy provides substantial benefit in terms of symptomatic improvement, reduced hospital admissions, prevention of progression of heart failure, delay of death and, most surprisingly, prevention of coronary events.

CFMC's CHF project involves a detailed CME program providing physician education regarding the appropriate use of ACE Inhibitors.

DIABETES IN THE HMO SETTING

Diabetes Mellitus is a chronic illness with the potential of significant socioeconomic impact.

Findings from the Diabetes Control and Complications Trial proved that tight glycemic control and quality health care substantially reduce complications associated with diabetes.

CFMC's HMO Diabetes project has the potential of improving the long-term complications of diabetes through preventive care and early monitoring. By working to improve physician practice patterns in an HMO outpatient setting, CFMC continues to expand its efforts in improving quality of care throughout Colorado and beyond.

INFLUENZA, PNEUMONIA AND TB

Every year pneumonia and flu take the lives of 40,000–70,000 Americans—a threat comparable to that of AIDS.

The overall costs to society of these and other vaccine-preventable diseases of adults exceeds 10 billion dollars each year.

Ninety percent of deaths caused by influenza, pneumonia, and TB occur in the Medicare population.

CFMC's Influenza, Pneumococcal and TB project focuses on significantly increasing the awareness and use of preventative measures to protect the over-65 population from each of these diseases.

PEPTIC ULCER DISEASE

In 1994, approximately 100,000 individuals were discharged from U.S. hospitals with a diagnosis of peptic ulcer disease or a related complication.

Individuals with peptic ulcer disease can be unknowingly infected for years or possibly a lifetime.

High recurrence of ulcers is commonly associated with H. pylori infection.

Approximately 500,000 new cases and an additional four million recurrent cases of peptic ulcer disease occur annually.

Although death from peptic disease is rare, an annual cost of 3–4 billion dollars is associated with this disease.

NSAID[5] use causes up to 50 percent of ulcers in the Medicare population.

Individuals developing ulcers or complications while on NSAID's should be counseled regarding associated risk factors.

An opportunity exists to improve screening for H. pylori by 46 percent in Colorado ulcer patients.

Left untreated, readmission rates of 50 percent in one year, 100 percent in two years, have been documented. With treatment, readmission rates of 5 percent in two years have been observed.

FROM OUR CUSTOMERS

With results from CFMC's Cooperative Cardiovascular Project, we now have a benchmark for treatment of patients with acute myocardial infarction.

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[5] Non-steroidal anti-inflammatory drugs, i.e. aspirin.

The Project's studies reassured us that the treatments and outcomes of patients at our hospital are comparable to those of our peer hospitals.

Importantly, these studies enable us to focus on enhancing specific therapies for acute MI patients.

BILL BRINTON, M.D.,
Medical Director, San Luis Valley Regional Medical Center.

The quality improvement focus of CFMC has been very helpful. The HCQIP projects have added impetus to Memorial Hospital's internal performance improvement efforts.

J. ROBERT PETERS,
Executive Director, Memorial Hospital—Colorado Springs.

The Colorado Society for Internal Medicine applauds CFMC's move from individual audit to review of disease management and trends. We believe this change allows CFMC to effect real change in the practice of physicians and that it will result in a significant contribution toward Quality Improvement in Colorado's health care system.

DAVID ABBEY, M.D.,
President, Colorado Society for Internal Medicine.

The ongoing confidential reporting system developed by CFMC and a multidisciplinary CQI team here at our Medical Center has proven to be a benefit to patient safety and the support of nurses in their practice. Improvements in the medications process include: decrease in time required by nurses, improved labeling on unit doses, fewer steps in obtaining IV piggybacks, decreased phone calls to the pharmacy, less confusion regarding the amount of drugs at the patient's bedside. Continued monitoring and process improvements are ongoing.

SHERYL GEORGE, R.N., C.N.S.,
Clinical Nurse Educator, Surgical Unit, McKee Medical Center.

I am writing to tell you the alert concerning ACE inhibitor use caused angioedema was very timely and useful. Estes Park Medical Center has encountered at least three cases of Angioedema directly caused by ACE Inhibitors.

12–17–95.—Female patient 75 yrs of age awoke during the night with swelling in her throat and increasing difficulty breathing. She presented with sore throat and tongue, swelling, increasing shortness of breath, trouble swallowing saliva, and coughing. She had been taking Prinivil 20 mg P.O.Q.D. for 4 weeks. The patient was hospitalized and treated with Solu-medrol 125mg IV, Benadryl 50 mg IV and Zantac 50 mg IV. She recovered fully and was released. There was no other reason for her symptoms. The diagnosis was Acute angioedema orophyrnyx. The adverse reaction was classified as "critical—life threatening" when reviewed by the Pharmacy and Therapeutics Committee.

8–10–95.—77 year old male patient presented with sudden onset of swelling of tongue to right side and swollen neck glands. Dyspnea was present, becoming more severe. Patient was treated with Solu-medrol 40 mg, Benadryl 50 mg P.O. and was later released without admission. Patient has just started taking Accupril 20 mg daily. Other medications were KCI P.O. 10 meq daily, and Furosemide 20 mg daily. Diagnosis was lingual angioedema. Upon review, the Pharmacy and Therapeutics Committee classified the adverse drug reaction as "critical".

There were two other cases of angioedema caused by ACE Inhibitors but I was not able to retrieve them.

All patients were cautioned that they cannot take any drug classified as ACE Inhibitors and to be sure they informed their physicians of this.

Please find enclosed the notice I sent to the medical staff after I received your notice.

The CFMC notice about ACE Inhibitor caused angioedema was useful and timely. Our medical staff is now acutely aware that ACE Inhibitors can cause this life-threatening syndrome. Thank you for allowing us to participate in this study. I also look forward to participating in the Atrial Fib study."

CLIFF STUART,
Consultant Pharmacist, Estes Park Medical Center.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS

The American Association of Clinical Endocrinologists provides a unified voice for clinical endocrinologists on issues affecting health care and the practice of endocrinology. As advocates for our patients, we are deeply concerned about maintaining

necessary access to endocrinologists for people with endocrine disorders, including diabetes, thyroid disease, osteoporosis, and other metabolic disorders. AACE appreciates the opportunity to offer our views on preserving the quality of health care to senior citizens and other vulnerable patient populations in an evolving health care climate.

In the elderly population, there is an increased likelihood that an individual will have two or more chronic conditions, and there is an association between the number of conditions present in one person and the occurrence of disability. The provision of care to people who are disabled contributes significantly to the financial costs paid by the government, private insurers, and to society as a whole; and this is expected to increase in the decade ahead. The increased costs to the Medicare program has led many health policy makers and members of Congress to recommend a full-fledged restructuring of Medicare, with emphasis on managed care principles. While AACE understands the need to curb the escalating costs of the program, we believe that designers of Medicare managed care delivery systems must allow for the fact that managed care strategies that are effective for the general public may not be the most therapeutic or cost effective for vulnerable populations such as senior citizens and the chronically ill.

For example, diabetes and osteoporosis are two chronic conditions frequently treated by endocrinologists for which specialized care has demonstrated benefits. Diabetes is the nation's fourth leading cause of death, affecting 14 million Americans at an annual expense in excess of $100 billion. Osteoporosis affects 2 million Americans at an annual expense of approximately $10 billion. However, with early detection and intensive management—treatment strategies that are often hindered by managed care hurdles—tremendous opportunity exists to enhance the health outcomes of individuals suffering from these conditions while reducing the expense of providing their care.

THERAPEUTIC BENEFITS AND COST-EFFECTIVENESS OF ENDOCRINE CARE

In patients with complex chronic conditions, including diabetes and other endocrine-related disorders, care by specialists who are specifically trained to treat these conditions has proven therapeutic and economic benefit. Diabetes treatment is a prime example of a chronic condition that offers potential for improved outcomes and cost-savings simultaneously. Virtually no other condition has a greater potential for a wide range of long-term negative health ramifications. Insufficient management of this condition inevitably leads to heart disease, blindness, kidney failure, amputation, and loss of life, which imposes great individual health burdens and increased cost to the health care system. Conversely, intensive diabetes management has been proven to improve outcomes and reduce complications and their associated health care costs. As demonstrated by the Diabetes Control and Complications Trial (DCCT), an NIH-sponsored trial completed in June, 1993, intensive regulation of blood sugar levels results in better outcomes and reduced incidence of complications. The preliminary results were so striking that the study was stopped after one year so that all participants could benefit from intensive blood sugar management. The results showed that intensive control resulted in a 75 percent reduction in early diabetic retinopathy, a 56 percent reduction in diabetic kidney disease, and a 60 percent reduction in nerve damage. The increased positive outcomes and decreased risk of complications, along with the attendant reduction in cost related to diabetic patient care, provide a compelling case for open access to endocrinologists for diabetic patients.

Similarly, osteoporosis is a disease that is largely preventable via early detection of low bone mass through specialized tests which endocrinologists are uniquely experienced in performing. With early detection and treatment, such as hormone replacement therapy, substantial cost savings can be realized through reduced incidence of fractures and subsequent hospitalizations, as well as improved quality of life of those affected.

SPECIALTY ACCESS REQUIREMENTS NEEDED FOR MEDICARE

In order to ensure that Medicare beneficiaries have the access to specialty care with proven benefits in terms of health outcomes and cost-effectiveness, AACE believes any health care delivery system choosing to participate in Medicare managed care programs should be required to provide access to the patient's specialist of choice, particularly to patients with chronic conditions. A mandatory Point-of-Service option (POS) should be made available to Medicare beneficiaries. Mandatory POS options will ensure that the long-term physician/patient relationships that form the core of effective endocrinology care will not be threatened, leading to fewer periods of patient disability and increased positive outcomes. Patients with life-threat-

ening diagnoses should not have their likelihood of survival depend on the length of time until their next annual open enrollment season. Without the POS option, patients will be discouraged from obtaining the comprehensive, cost-effective, cognitive level of care that is most appropriate for their needs.

In addition, subspecialists such as endocrinologists should be allowed to act as primary care physicians for the chronically ill patient populations that they are specifically trained to treat. As primary care physicians, endocrinologists are able to provide patients with diabetes with the intensive condition management proven to achieve optimal results without the unnecessary encumbrance of repeated referrals. The results of the DCCT provide striking evidence that endocrinologists, acting as the patients' primary care physician as well as the subspecialist best trained to care for their chronic conditions, can greatly enhance both improved health outcomes and cost-effectiveness.

Finally, subspecialists such as endocrinologists should be allowed to act as primary care physicians for some patients and as consultants for other patients. When managed care plans force subspecialists to limit their scope of practice to either primary care or consultative care, subspecialist physicians choosing to practice as primary care physicians are denied the right to practice in their field of specific expertise and thus cannot help those patients most in need of their skills and training. Conversely, those choosing to act as subspecialist consultants are prevented by gatekeeper requirements from providing their patients the intensive illness management proven to achieve optimal health outcomes. In either case, the best interests of the patients are not being served and the subspecialist's ability to provide the most effective, cost-efficient level of care possible is compromised. It is important to note though, that because they were first trained in general internal medicine, endocrinologists still have the requisite "core" training to provide comprehensive primary care to their patients. We feel that managed care entities should not automatically assume that because of the specialist nature of endocrinology that its practitioners cannot or do not serve as their patients primary care physician. Often, patients with diabetes or a related diseases rely on his or her endocrinologist for the full continuum of care, both primary and specialty.

AACE strongly urges Congress to promote access to subspecialty physicians by requiring mandatory POS options and allowing subspecialists to act as either primary care physicians or consultants for the chronically ill patient populations that they are specifically trained to treat. In view of the high costs of disability, medical care and surgery associated with the progression of chronic diseases, the data demonstrating the benefits of specialty access have important financial and medical implications. Health care payers that make it difficult for vulnerable patient populations such as patients with diabetes, osteoporosis, thyroid disease and other metabolic disorders to see an endocrinologist could be delaying positive outcomes for the patient while increasing the costs of care to the patient's health plans.

The AACE appreciates the opportunity to present our views on these matters.

Prepared Statement of the American College of Rheumatology

The American College of Rheumatology is an organization of physicians, health professionals, and scientists that serves its members through programs of education, research and advocacy that foster excellence in the care of people with arthritis and rheumatic and musculoskeletal diseases. The ACR appreciates the opportunity to offer our views on preserving the quality of health care to senior citizens and other vulnerable patient populations in an evolving health care climate.

Arthritis ranks #1 among the ten leading health problems of individuals age 50 and older. No condition impairs the quality of life of more older adults—and does so to a greater extent—than does arthritis. In the elderly population, there is an increased likelihood that an individual will have two or more chronic conditions, and there is an association between the number of conditions present in one person and the occurrence of disability. The provision of care to people who are disabled contributes significantly to the financial costs paid by the government, private insurers, and to society as a whole; and this is expected to increase in the decade ahead.

The ACR is aware that the costs of the federal Medicare program continue to increase well above the Consumer Price Index. The increased costs of the program have led many health policy makers and members of Congress to recommend a full-fledged restructuring of Medicare, with emphasis on managed care principles. While the ACR understands the need to curb the escalating costs of the program, we believe that designers of Medicare managed care delivery systems must allow for the fact that managed care strategies that are effective for the general public may not

be the most therapeutic or cost effective for vulnerable populations such as senior citizens and the chronically ill.

THERAPEUTIC BENEFITS AND COST-EFFECTIVENESS OF RHEUMATOLOGIC CARE

A study performed by the California Pacific Medical Group on patients with arthritis and related conditions indicated that patients with rheumatologists as their primary care physicians had an average total cost per patient per month that was 35 percent less than patients who had non-rheumatologists as their primary care physicians. Another study showed that rheumatologists' initial diagnoses of hospitalized acute arthritis patients are often more accurate than diagnoses made by non-rheumatologists. Consequently, treatment of these people by rheumatologists led to swifter improvement and briefer hospital stays. Average cost of care for these arthritis patients (those treated by a rheumatologist) was $8,756, while care by non-rheumatologists averaged $14,750, a cost savings of 41 percent. According to further research, patients with arthritis and related diseases who visit a rheumatologist quarterly are more likely to see improvements in their first year of treatment than patients who visit a rheumatologist less regularly. Obviously, closely monitoring the condition of a patient with arthritis or a related condition decreases the likelihood of expensive hospital stays or invasive procedures.

Therapeutic benefit also results from rheumatologically coordinated care. Less fragmentation of the patient's continuous long-term care, whether caused by an arbitrary guideline or financial disincentive, will lead to more effective care management and greater patient comfort levels. Examples of arbitrary guidelines that fragment coordinated care are the use of non-specialty gatekeepers that create hassles for both patients and physicians, and policies that force subspecialists to limit their scope of practice to either primary care or consultative care. Financial disincentives that restrict provider access utilized by some healthcare delivery systems include the use of higher deductibles and lower coinsurance rates for services rendered by non-network providers. When patients have open access to specialists, their conditions invariably improve, and their degree of comfort will be higher (via increased compliance with their prescription regimen).

SPECIALTY ACCESS REQUIREMENTS NEEDED FOR MEDICARE

In order to ensure that Medicare beneficiaries have the access to specialty care with proven benefits in terms of health outcomes and cost-effectiveness, ACR feels that health delivery systems must be subject to several requirements in order to participate in the Medicare managed care program. First, a mandatory Point-of-Service option (POS) must be made available to Medicare beneficiaries. Mandatory POS options will ensure that the long-term physician/patient relationships that form the core of effective rheumatologic care will not be threatened, leading to fewer periods of patient disability and increased positive outcomes. Patients with life-threatening diagnoses should not have their likelihood of survival depend on the length of time until their next annual open enrollment season. Without the POS option, patients will be discouraged from obtaining the comprehensive, cost-effective, cognitive level of care that is most appropriate for their needs.

Second, subspecialists such as rheumatologists must be allowed to act as primary care physicians for the chronically ill patient populations that they are specifically trained to treat. As primary care physicians, rheumatologists will have the opportunity to provide patients with arthritis or a related diseases with the intensive condition management proven to achieve optimal results without the unnecessary encumbrance of repeated referrals. Evidence abounds that rheumatologists often act as the patients' primary care physician as well as the subspecialist best trained to care for their chronic conditions. A study conducted in the 1970's, by the Robert Wood Johnson Foundation and the University of Southern California analyzed medical services provided by physicians in 24 medical subspecialties, including rheumatology. The study noted that for a significant percentage of their patient population, internal medicine subspecialists provided regular patient care, and met most of their patients' needs. The study further indicated that rheumatologists provided a significant percentage of primary care to their patients, some 52.9 percent. The study clearly demonstrates that rheumatologists provides a substantial amount of primary care as well as specialty care.

Finally, subspecialists such as rheumatologists should be allowed to act as primary care physicians for some patients and as consultants for other patients. When managed care plans force subspecialists to limit their scope of practice to either primary care or consultative care, subspecialist physicians choosing to practice as primary care physicians are denied the right to practice in their field of specific expertise and thus cannot help those patients most in need of their skills and training.

Conversely, those choosing to act as subspecialist consultants are prevented by gatekeeper requirements from providing their patients the intensive illness management proven to achieve optimal health outcomes. In either case, the best interests of the patients are not being served and the subspecialist's ability to provide the most effective, cost-efficient level of care possible is compromised. It is important to note though, that because they were first trained in general internal medicine, rheumatologists still have the requisite "core" training to provide comprehensive primary care to their patients. We feel that managed care entities should not automatically assume that because of the specialist nature of rheumatology that its practitioners cannot or do not serve as their patients primary care physician. Often, patients with arthritis or a related disease rely on his or her rheumatologist for the full continuum of care, both primary and specialty.

The ACR strongly urges Congress to promote access to subspecialty physicians by requiring mandatory POS options and allowing subspecialists to act as either primary care physicians or consultants for the chronically ill patient populations that they are specifically trained to treat. In view of the high costs of disability, medical care and surgery associated with the progression of chronic diseases such as osteoarthritis, osteoporosis, and other diseases of the muscles, bones, and joints, the data demonstrating the benefits of specialty access have important financial and medical implications. Health care payers that make it difficult for vulnerable patient populations such as patients with arthritis or related diseases to see rheumatologists could be delaying positive outcomes for their patients while increasing the costs of care to the patient's health plans.

The ACR appreciates the opportunity to present our views on these matters.

Prepared Statement of the American Occupational Therapy Association

Summary

The American Occupational Therapy (AOTA) appreciates the opportunity to submit testimony to the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations addressing the quality of health care provided to Medicare patients enrolled in health maintenance organizations (HMO's).

As Congress looks to managed care as a solution to controlling health care costs, steps need to be taken to ensure that consumers have access to the care they need and that undue pressures to control costs are not applied that threaten the quality of care. Significantly worse health outcomes were reported for HMO-enrolled chronically ill elderly patients compared to those in fee-for-service in a study conducted by John Ware of the New England Medical Center.

The AOTA has heard from occupational therapy practitioners and their patients regarding the utilization management methods and procedures followed by managed care organizations (MCO's), as well as information disclosure restrictions that have had serious consequences for access to rehabilitative care. Reports have described procedures where the review process does not involve adequately trained medical personnel even for critical care cases, the treating health professionals are not consulted, and patient charts are not reviewed. Patients and their families have a difficult time getting access to information concerning health plan decisions such as the criteria and steps followed to approve care, credentials of reviewers, and the health plan's policies regarding grievance procedures and appeal rights. Routinely, arbitrary time or visit limits are placed on rehabilitative care without review of a patient's individual needs.

Also evident in these cases are the added burdens and pressures placed on specialist physicians to intervene on behalf of the patient. MCO gatekeepers are often not experienced in the diagnosis and treatment of more chronic care conditions. Occupational therapy practitioners report that the amount of time the specialist spends negotiating on the patient's behalf and explaining complicated diagnoses to gatekeepers is troubling.

Federal oversight is necessary to ensure that access to high quality health care is not compromised. Congress should take action to require that all types of health plans, including plans that serve Medicare patients, comply with uniform national standards. These standards should: (1) require health plans to meet specific utilization review and information disclosure standards; (2) prohibit discriminatory practices against health care providers; (3) require health plans to demonstrate their capacity to meet the full range of health care needs of enrollees appropriately; (4) guarantee that consumers will have access to specialized care including out-of-net-

work care; and (5) require due process protections for consumers and health care providers.

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit testimony to the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations addressing the quality of health care provided to Medicare patients enrolled in health maintenance organizations (HMO's).

The AOTA represents the professional interests of 56,000 occupational therapists, occupational therapy assistants and students of occupational therapy. Occupational therapy practitioners provide services to millions of people of all ages each year in hospitals, nursing facilities, outpatient rehabilitation clinics, psychiatric facilities and school systems, through home health agencies and offices of independent practitioners.

The treatment goals of an occupational therapy practitioner focus on promoting independence and preventing further disability. The therapist's interventions are designed to assist individuals in overcoming or adapting to limitations imposed by an illness or injury and to improve the extent of functional recoveries. From a managed care perspective, offering occupational therapy as an integral part of treatment avoids unnecessary medical expenses and prevent incidents of long term disability. Occupational therapy practitioners work with individuals with a range of problems such as strokes, spinal cord injuries, cancer, severe head injuries, congenital defects, mental illness, and multiple sclerosis. Occupational therapy helps patients, families and insurance companies avoid the costly consequences of dependent living.

As Congress looks to managed care as a solution to controlling health care costs, steps need to be taken to ensure that consumers have access to the care they need and that undue pressures to control costs are not applied that threaten the quality of care. Currently no uniform national standards exist holding the various types of managed care organizations (MCO's) accountable under the same standards for the care they provide to consumers.

Cost is still more important than the quality of care in today's managed care market and MCO's who have elected to focus on quality have not been rewarded for their efforts. A recent survey by William M. Mercer, Inc. of 196 mid-size to large companies identified cost as the most important factor to consider when contracting with a managed care plan. While quality care was cited as important to many of these companies, only 20 percent identified an HMO's accreditation by the National Committee for Quality Assurance (NCQA) as important. Many HMO's have complained of losing business to unaccredited HMO's and are frustrated that their efforts to seek accreditation have not resulted in rewards by way of increased enrollments or higher profits.

The quality of care of chronically ill elderly patients receiving care through HMO's was recently questioned in a study conducted by John Ware of the New England Medical Center. The study found significantly worse health outcomes for HMO-enrolled patients compared to patients receiving care through fee-for-service arrangements, suggesting the need for more careful scrutiny of the quality of care provided to Medicare patients through HMO's and other types of MCO's.

ACCESS TO REHABILITATIVE CARE

The AOTA has heard from occupational therapy practitioners and their patients regarding the utilization management methods and procedures followed by MCO's, as well as information disclosure restrictions that have had serious consequences for access to rehabilitative care. Reports have described procedures where the review process does not involve adequately trained medical personnel even for critical care cases, the treating health professionals are not consulted, and patient charts are not reviewed. Patients and their families have a difficult time getting access to information concerning health plan decisions such as the criteria and steps followed to approve care, credentials of reviewers, and the health plan's policies regarding grievance procedures and appeal rights. Routinely, arbitrary time or visit limits are placed on rehabilitative care without review of a patient's individual needs.

Also evident in these cases are the added burdens and pressures placed on specialist physicians to intervene on behalf of the patient. MCO gatekeepers are often not experienced in the diagnosis and treatment of more serious chronic care conditions. Occupational therapy practitioners report that the amount of time the specialist spends negotiating on the patient's behalf and explaining complicated diagnoses to gatekeepers is troubling.

One case recently brought to our attention involved a patient who sustained severe head injuries as a result of an automobile accident. Initially the family's managed care organization refused to pay for their son's rehabilitation, despite numer-

ous recommendations from the physicians treating him. Only after hiring an attorney and launching a letter writing campaign did the MCO relent and provide the services the son needed. The necessary rehabilitative care would probably not have been approved had the parents not been tenacious in their efforts to seek outside help from public officials. In addition, the two month delay in initiating treatment could adversely affect the patient's prognosis and ultimate level of recovery.

Information disclosure restrictions have been a problem for occupational therapists. An increasing number of occupational therapy practitioners have been required to sign contracts containing "gag" clauses. These clauses have varied in scope from preventing occupational therapy practitioners from discussing treatments with patients to prohibiting occupational therapy practitioners from divulging financial arrangements with the MCO. These clauses typically contain a threat of immediate termination for violations of the provision.

Many occupational therapists report of changes in the way they interact and share information with their patients as result of these clauses and more subtle unwritten pressures from the MCO's. Occupational therapy practitioners have been particularly conflicted on what to tell their patients in situations where the amount of rehabilitative care approved by the MCO has expired and the patient still requires medically necessary care.

The AOTA has also heard from members regarding MCO's that do not offer occupational therapy services or allow occupational therapy practitioners to participate in provider networks. Some MCO's have contracted exclusively with preferred provider rehabilitation networks that don't include occupational therapists on their panels. In other cases, MCO's won't reimburse occupational therapy practitioners for services they are qualified to provide, even in cases where they have already provided the service. One area where this has been a problem is with hand therapy, an area of subspecialty in which both occupational therapists and physical therapists practice. Occupational therapy practitioners have described instances where the service has been pre-approved by the MCO, but when the occupational therapist submits a claim for payment, payment is denied because the MCO's policy only recognizes physical therapists as providers of hand therapy.

FEDERAL OVERSIGHT IS NEEDED

Federal oversight is necessary to ensure that access to high quality health care is not compromised. Congress should take action to require that all types of health plans, including plans that serve Medicare patients, comply with uniform national standards. These standards should.

(1) *Require health plans to meet specific utilization review and information disclosure standards.*—An increasing number of health plans are implementing utilization review procedures to control the use of health care services. These procedures should not only be used as a mechanism to control costs but should also ensure access to appropriate care when necessary. Health plans should operate utilization review practices that require staff involved with making both non-emergency and emergency care decisions to be clinically trained. Care decisions in which specialized training is required, particularly for individuals with complex or chronic health decisions, should involve health professionals qualified to review the provision of such services, and give consumers the option of choosing a specialist as their gatekeeper.

Under information disclosure and reporting requirements health plans should be required to provide enrollees with truthful, accurate and easily understandable marketing materials and information about coverage provisions, benefits and exclusions by category of service and type of health professional. This is particularly important for elderly patients who may not have family to rely on to help them understand this information. Financial information should also be available including the financial arrangements between the plans and providers including incentive and bonus options, as well as information on the percentage of health care dollars that go to profits and administration.

(2) *Prohibit discriminatory practices against health care providers.*—It is important that reasonable access to occupational therapy practitioners and other health professionals be guaranteed to ensure consumers' health care needs are met. An essential first step for creating equitable access to all health professionals is to incorporate into any health care legislation antidiscrimination requirements that prohibit health plans from arbitrarily excluding entire classes or types of health professionals from their provider panels/networks on the basis of their category of licensure or certification.

This antidiscrimination language is not "any willing provider" language. It does not require a health plan to enter into a contract with every individual practitioner, but rather would require the plan to have a representative variety of health profes-

sions in its network or on its provider panel. Antidiscrimination language is intended to give health plans more flexibility than "any willing provider" requirements by allowing health plans the discretion to contract selectively on the basis of an individual health professional's reputation, professional qualifications, and evidence of cost-effective, quality care.

(3) *Require health plans to meet specific capacity standards.*—Legislation should ensure that health plans have the resources and capacity to meet the needs of plan enrollees. Health plans must be certified and demonstrate their ability to meet the full range of health care needs of enrollees appropriately, including requiring that they have a sufficient number, mix and distribution of health professionals in their network panel; ensure covered services are available and accessible in the service area of the plan, through a variety of sites with reasonable proximity to the residences and workplaces of enrollees; provide services with reasonable promptness (including reasonable hours of operation and after-hour services); and reasonably assure the continuity of care.

(4) *Guarantee that consumers will have access to specialized care including out-of-network care.*—Consumers need to know they will have access to specialized care if necessary. If this care is not available within a health plan's network, or the consumer is concerned about the type or quality of this care, they need to know they can seek help outside the network at a higher reasonable copayment. Two alternative approaches have been proposed to address access to care outside of a health plan's network. One option is to require the MCO that offers a closed panel plan (e.g. a staff-model health maintenance organization) to also offer a point-of-service plan. The other option is to require all MCO's, regardless of their type, to allow enrollees to go out of network to receive care, applying an additional copayment requirement.

(5) *Require due process protections for consumers and heath care providers.*—As health plans develop new procedures for controlling the utilization of care, consumers and providers must have some recourse for questioning health plan decisions. Due process protections provide a mechanism by which consumers and providers are informed of health plan decisions that affect their participation and delivery of care and are offered an opportunity to respond to these decisions, especially when access to care is denied.

Under due process protections for providers, health plans should be required to follow certain procedures in creating and maintaining network of providers, such as publishing the criteria for participation in the network and providing for an appeals process in the event of termination of a provider from in the network.

MEDICARE REFORM LEGISLATION SHOULD INCLUDE QUALITY STANDARDS

The AOTA urges the Subcommittee to examine issues with managed care that have been raised through various legislation introduced and to require MCO's to meet specific quality standards as a condition to participation in the Medicare program.

The Patient Communications Protections Act introduced by Senator Ron Wyden (D–OR) seeks to define the "anti-gag" rules between MCO's and health care providers. This legislation represents a major step toward protecting important provider-patient communication and curbing a range of abuses. Communication is particularly important with elderly patients who often become more dependent on their health care providers and require more assistance.

On the House side, Representatives Charles Norwood (R–GA) and Bill Brewster (D–OK) have introduced the Family Health Care Fairness Act (H.R. 2400) which establishes uniform national standards for all types of health plans including self-insured plans. The AOTA appreciates the work that went into drafting this bill, and applauds their efforts to incorporate the best policies of those managed care organizations that voluntarily require providers to emphasize quality care and consumer involvement. We urge the Subcommittee to carefully examine each of the issues addressed in this bill and respond to the concerns of Medicare beneficiaries.

UNIFORM STANDARDS CAN BENEFIT EVERYONE

Requiring MCO's to meet basic standards can benefit everyone. Reports that the managed care industry has reached a maturation point, with too many companies competing in the market, means MCO's will be looking for new ways to cut costs as competition intensifies. The fear is that MCO's will compete by lowering costs and not attend to the quality of their product. Requiring each MCO to meet the same standards can put all health plans on a level playing field, setting the stage for real competition.

Standards can reassure citizens that their legislators support the need for quality health care when they promote the use of managed care as a way to cut health care costs. Standards can also provide assurances to a growing Medicare population that MCO's are worth moving into. Employers who are increasingly putting their own pressure on MCO's to meet credentialing standards can be assisted by national standards.

The AOTA appreciates the Subcommittee's interest in holding a hearing to discuss these important issues. The Association and our 56,000 members are committed to providing the public with quality occupational therapy services and the delivery of quality care by appropriately trained health care professionals in managed care plans. We will support and work to secure constructive proposals to achieve those ends.

We look forward to more hearings and further discussion with organizations who represent the interests of a broad range of health professionals and services. We urge the Subcommittee to address a variety of issues including how managed care organizations are planning for, and serving the needs of, elderly patients with more serious chronic health care conditions.

We appreciate the opportunity to submit this statement for the record, and look forward to working with Senator Specter and the members of the Subcommittee to ensure Medicare beneficiaries receive quality health care services through HMO's and other types of managed care organizations.

LETTER FROM DONALD W. FISHER

AMERICAN MEDICAL GROUP ASSOCIATION,
Alexandria, VA, December 4, 1996.

Senator ARLEN SPECTER,
Chairman, Senate Labor/HHS Appropriations Subcommittee,
Washington, DC.

DEAR CHAIRMAN SPECTER: I am writing to provide additional information for the record of the Nov. 13, 1996 subcommittee hearing on Quality of Care in Managed Care Settings pursuant to your request of Dr. Robert Margolis.

You requested that the American Medical Group Association supplement our formal testimony with further information regarding compensation of physicians in organized medical groups, and on the measurement of patient satisfaction. Both areas of your interest are relevant to the topic of the hearing and an appreciation for the emerging sciences of organizational management of medicine and clinical outcomes research.

PHYSICIAN COMPENSATION

Compensation trends in medical groups have changed significantly since Congress enacted legislation establishing a Medicare fee schedule for physicians services. Congress' stated intent in enacting the Medicare fee schedule was the rationalization of payment for physician services. But while HCFA was implementing the fee schedule, the market for physician services has changed. Many group practices have restructured the formulas by which physicians are compensated to assure that all personnel are fairly compensated for their contribution to the mission of the group practice.

There are many methodologies for determining the income of physicians in group practices. The Medicare fee schedule established unit prices for all distinct services and procedures. The 'relative value units' established by HCFA have become the basis of many independently created measures of productivity, but pure fee-for-service reimbursement is giving way to salary structures coupled with incentive programs designed to facilitate the medical mission of the organization which employs or contracts with physicians.

State-of-the-art physician compensation systems are rapidly changing as provider services have come to be viewed as cost centers as opposed to revenue centers. The variables which an organization measures to determine the relative productivity of members of the group varies but might include:

—patient encounters, panel and non-panel;

—quality of care, measured by total of charts reviewed, percentage rated satisfactory or superior, and CME credits;

—quality of service measured through patient satisfaction ratings, patient complaints, liability claims, compliments, office visits, new office visits, consultations, and complete physical exams;

—cost effectiveness, measured by primary care physician panel activity, total cost of external referrals, ancillary service utilization, and length-of-stay in acute or SNF facilities;
—organizational participation measured by participation in staff, department, or committee meetings, CQI/guideline meetings, hospital and specialty society meetings, and community activities;
—contributions to medical education; and
—research activities.

The difficult challenge to an integrated delivery system comes as it merges data from fee-for-service and capitated systems. Rarely do the physicians and other care providers know, or have any way of knowing, the source of reimbursement for an individual patient. But once the efficiencies of capitation are realized among clinicians in the group, the mindset which results is heavily biased towards patient and care management.

There is a significant and growing body of research now demonstrating that patient care management not only leads to superior clinical outcomes, but also is more economically efficient.

As a matter of efficient public policy, the challenge to you as the Chairman of the Senate Appropriations Subcommittee responsible for HHS appropriations is to identify what mechanisms create these efficiencies and support them. We urge you to carefully consider accelerating the rate of funding for clinical outcomes research conducted under the auspices of the Agency for Health Care Policy and Research.

PATIENT SATISFACTION

In September of 1995, the American Medical Group Association launched a collaborative project with several of our members to collect a standard set of patient satisfaction information. Within this initiative, our medical groups are able to benchmark and compare their patient satisfaction results by using a standardized patient satisfaction measure and protocol provided by AMGA. Participants of this data collection effort use the survey results for the periodic monitoring of the quality of care provided within their own group practices and benchmarking physician level results for quality improvement purposes.

I have enclosed a copy of AMGA's Outcomes Measurement Consortia: Patient Satisfaction Overview which will provide you with a more detailed explanation of this project to improve the quality of medical care for thousands of patients. AMGA strongly believes that it is this type of research that should be encouraged and supported. We urge Congress to continue funding the outcomes measurement efforts undertaken by organizations like ours and the Agency for Health Care Policy and Research.

CONCLUSION

We hope these comments are helpful to you as you prepare for the 105th Congress. As always, we stand available and eager to discuss these issues with you further.

Sincerely,

DONALD W. FISHER,
Ph. D., CAE, Chief Executive Officer.

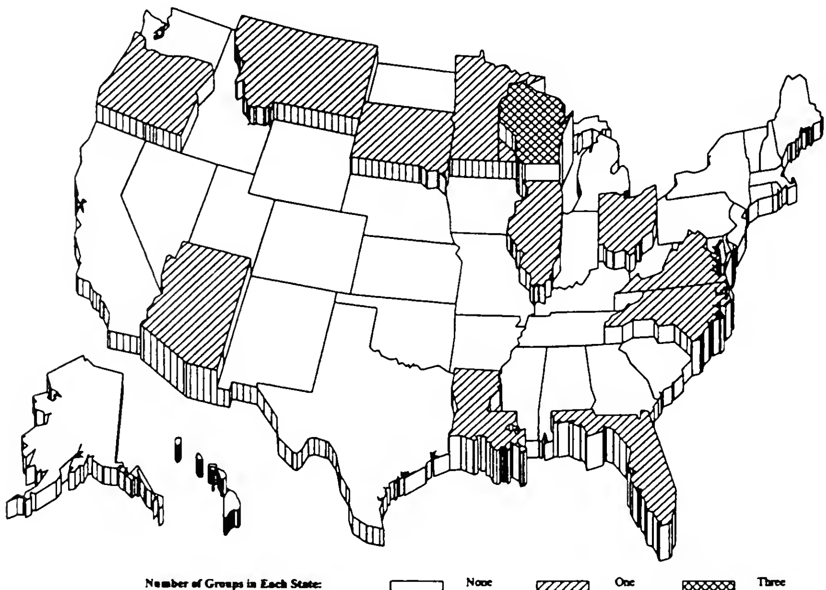
Patient Satisfaction Consortium Overview

Introduction

Starting in September of 1995, several members of the American Medical Group Association (AMGA) began a collaborative project to benchmark their patient satisfaction results by using a standardized patient satisfaction measure and protocol provided by AMGA. Members of the consortia are using the survey results for the periodic monitoring of the quality of care provided within their own group practices and benchmarking physician level results for quality improvement purposes. Individual providers compare themselves to other physicians within their respective practices, to a national like-specialty benchmark, and to the database at the aggregate level. Where applicable, physician results from previous data collection cycles are also provided as a benchmark of quality improvement. The participating multispecialty groups are able to compare their results with complete confidentiality.

Currently, there are 14 medical groups that have contributed data to the AMGA patient satisfaction database. The figure below graphically represents the geographic location of these group practices by state. To date, 44,780 patient satisfaction records have been contributed to the database by almost 1,000 physicians.

Geographical Representation of Patient Satisfaction Participation



The Survey

To collect the patient satisfaction data, patients are asked to complete a questionnaire during their clinic visit that includes a set of nine items adapted from the Group Health Association of America (now the American Association of Health Plans) Visit-Specific Questionnaire (Ware & Hays, 1988; Davies & Ware, 1991). The nine-item core survey is composed of three questions regarding accessibility of care, five questions pertaining to quality of care, and an overall visit rating.

The accessibility dimension (questions 1 to 3) is assessed through questions regarding:

- APPOINTMENT WAIT
- OFFICE LOCATION
- TELEPHONE ACCESS

The acceptability of the visit (questions 4 to 8) is assessed by rating:

- OFFICE WAIT
- TIME SPENT WITH PROVIDER
- EXPLANATION OF WHAT WAS DONE
- TECHNICAL SKILLS OF PROVIDER
- PERSONAL MANNER OF PROVIDER

The overall rating of the visit is captured by question 9:

- VISIT OVERALL

Finally, questions 10 to 13 assessing the patient's health status, endorsement of the provider, gender, and age are included. Health status, age, and gender are used to interpret provider- and clinic-level ratings. Past experience suggests that this integrated survey may be completed by most patients in one to two minutes.

	Internal Office Use Only 1-Scheduled 2-Walk In Payer Code _ _ _ _ Date ___/___/___

PATIENT SATISFACTION SURVEY

Thinking about your visit with the person you saw, how would you rate the following:

(Check one box on each line)

	Poor	Fair	Good	Very Good	Excellent
1. How long you waited to get an appointment	▢	▢	▢	▢	▢
2. Convenience of the location of the office	▢	▢	▢	▢	▢
3. Getting through to the office by phone	▢	▢	▢	▢	▢
4. Length of time waiting at the office	▢	▢	▢	▢	▢
5. Time spent with the person you saw	▢	▢	▢	▢	▢
6. Explanation of what was done for you	▢	▢	▢	▢	▢
7. Technical skills (thoroughness, carefulness, competence) of the person you saw	▢	▢	▢	▢	▢
8. The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw	▢	▢	▢	▢	▢
9. The visit overall	▢	▢	▢	▢	▢
10. In general, would you say your health is	▢	▢	▢	▢	▢

	Definitely not	Probably not	Probably yes	Definitely yes
11. Would you recommend the person you saw to your family or friends?	▢	▢	▢	▢

12. Are you (patient) male or female? MALE FEMALE

13. How old were you (patient) on your last birthday? ___ ___ ___ Years

Methodology

Patient Sampling and Selection

A selection of patients, representative of each provider's usual practice, is asked to complete the visit-specific patient satisfaction survey. Patient selection is systematic based on the average number of patients visiting a provider during a typical week. A patient selection matrix is provided by AMGA to determine the sampling procedure which is based on each provider's weekly volume. Administration of patient surveys continues on consecutive days in the clinic until a minimum 30 completed surveys per provider has been reached. Experience suggests that clinics should be able to complete 12 to 20 surveys a week for each provider and that the entire sample can be completed in two to three weeks.

Patient Eligibility

The following is inclusion and exclusion criteria for survey administration.

INCLUDE THE FOLLOWING:

- any patient 16 years of age or older
- any caregiver (e.g., parent, grandparent, sibling 16 years of age or older, or child care provider) for a child under 16 years of age
- any caregiver (e.g., parent, spouse, significant other) for patients with severe cognitive impairments (e.g., Alzheimer's patients) or with severe sensory-motor impairments, or for patients unable to read the satisfaction survey.

EXCLUDE THE FOLLOWING:

Patients meeting the following criteria who are unaccompanied by a caregiver:

- severe cognitive impairments (e.g., Alzheimer's patients)
- severe sensory-motor impairments
- inability to read the satisfaction survey
- under 16 years of age

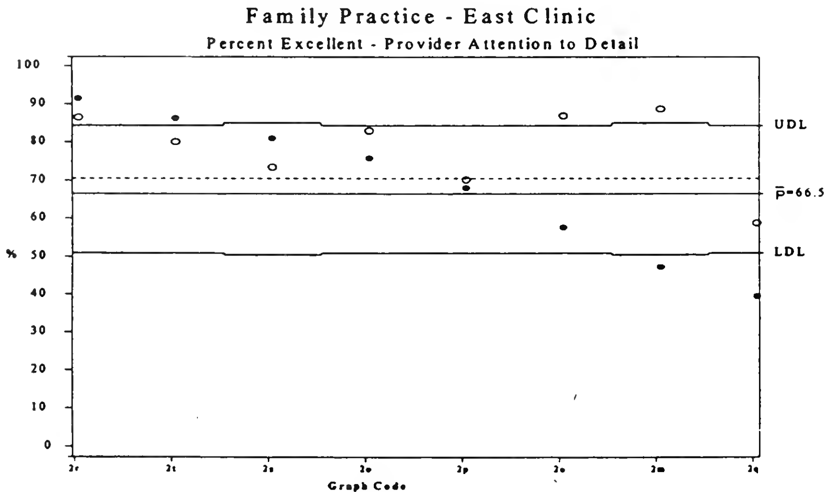
Data Collection

Upon arriving for a provider encounter, each eligible patient is handed a survey either in an envelope or folder with the written instructions attached to the outside. The patient is asked to complete the survey immediately **after** seeing the provider, but **before** leaving the office. An alternative method is to ask the patient to stop back at the reception desk **after** seeing the provider, but **prior** to leaving the office in order to complete a survey. Patients **should not be permitted** to return completed forms to the clinic by mail. Provide a confidential drop-box or bin for patients to return completed surveys. Maintain a running total of forms completed for each provider until you have 30 completed surveys.

Data Analysis & Reporting

AMGA encourages all participants to create a "non-critical" and "non-threatening" atmosphere when reviewing results. Report design should insure that the identity of the provider is confidential and known only to him/herself. To ensure this, AMGA reports all results with the clinic name and physician name coded.

Results from the visit-specific satisfaction survey are reported in terms of the percentage of 'Excellent' on responses on each question. This is the standard analysis approach for this instrument and has been shown by the Health Outcomes Institute to be highly discriminating. Graphical presentation of the provider's percentage of excellent responses shown in context with the database benchmarks can be a very powerful tool for improving the quality of care delivered. For example, in the sample graph below eight family practice physicians from within the 'East Clinic' are compared on their attention to detail (not a real question). The aggregate percentage 'Excellent' is 66.5 percent, the aggregate family practice specialty benchmark is 71 percent. The individual physician results are reported for the current data collection period (solid dot) and for the previous period (empty circle) if they participated.



<u>Definition of Database Benchmarks</u>

Aggregate Benchmark: The overall cumulative results of the entire patient satisfaction database. This is represented by a *solid line* on each graph.

Like-Specialty Benchmark: The overall cumulative results of the patient satisfaction database for the specific specialty of the physician. This is represented by a *dashed line* on each graph.

Quality-Improvement Benchmark: The physician-level results from previous reporting cycles. This is represented by an *open dot* on the same vertical axis as the current results for the specific physician. Current results for the specific physician are represented by a *solid dot.*

Calculating Probability Decision Limits

This section of the document provides background information on the methodology used by AMGA to calculate the probability limits used in the graphs.

Analysis of Means for Proportions

Analysis of means is a graphical and statistical method for simultaneously comparing a group of z treatment mean proportions with the grand mean proportion at a specified significance level α. This method can be thought of as an alternative to analysis of variance for a fixed effects model. Analysis of means can also be thought of as an extension of the Shewhart chart because it considers a group of sample means instead of one mean at a time in order to determine whether any of the sample means differ too much from the overall mean. The analysis of means has the same graphical presentation as a control chart except that the decision limits are computed differently (see below).[1]

An analysis of proportion graph answers the question, "Do any of the physician ratings differ significantly from the overall average rating?" If the physician result for the current round falls above or below the decision limit range, the answer to the question would be the physician has a significantly different rating than the overall rating. Such a difference cannot be attributed to chance variation alone.

Calculating Control and Probability Limits[2]

The following notations are used:

p_i	is the proportion of excellent for the ith physician
X_i	is the number of excellent for the ith physician
n_i	is the number of non-missing responses for the ith physician
N	Number of Physicians
$\bar{p}$	average proportion of excellent taken across all physicians in the database:

$$\bar{p} = \frac{n_1 p_1 + \ldots\ldots + n_N p_N}{n_1 + \ldots\ldots + n_N} = \frac{X_1 + \ldots\ldots X_N}{n_1 + \ldots\ldots + n_N}$$

$I_T(\alpha, \beta)$ incomplete beta function:

$$I_T(\alpha, \beta) = \left(\Gamma(\alpha + \beta) / \Gamma(\alpha)\Gamma(\beta)\right)\int_0^T t^{\alpha-1}(1-t)^{\beta-1}dt$$

for $0 < T < 1$, $\alpha > 0$, and $\beta > 0$, where $\Gamma(\cdot)$ is the gamma function

1. Rodriquez, Robert, N. "Health Care Applications of Statistical Process Control: Examples Using the SAS® System," SAS Users Group International: Proceedings of the Twenty First Annual Conference, 1381-1396.
2. SAS Institute Inc., SAS/QC Software: Usage and Reference, Version 6, First edition, Volume 2, Cary, NC: SAS Institute Inc., 1995

The control limits are computed as a specified multiple (k) of the standard error of pi above and below the central line.

The lower and upper control limits, LCL and UCL, respectively, are computed as

$$\text{LCL} = \max\left(\bar{p} - k\sqrt{\bar{p}(1-\bar{p})/n_i}, 0\right)$$

$$\text{UCL} = \min\left(\bar{p} + k\sqrt{\bar{p}(1-\bar{p})/n_i}, 1\right)$$

A lower probability limit for p_i can be determined using the fact that

$$\begin{aligned} P\{pi<LCL\} &= 1-P\{p_i \geq LCL\} \\ &= 1-P\{X_i \geq n_i LCL\} \\ &= 1 - I_{\bar{p}}(n_i LCL, n_i + 1 - n_i LCL) \\ &= I_{1-\bar{p}}(n_i + 1 - n_i LCL, n_i LCL) \end{aligned}$$

The lower probability (LCL) limit is calculated by setting

$$I_{1-\bar{p}}(n_i + 1 - n_i LCL, n_i LCL = \alpha/2)$$

and solving for LCL. Similarly, the upper probability limit for pi can be determined using the fact that

$$\begin{aligned} P\{p_i > UCL\} &= P\{p_i > UCL\} \\ &= P\{Xi > n_i UCL\} \\ &= I_{\bar{p}}(n_i UCL, n_i + 1 - n_i UCL) \end{aligned}$$

The upper probability limit UCL is then calculated by setting

$$I_{\bar{p}}(n_i UCL, n_i + 1 - n_i UCL) = \alpha/2$$

and solving for UCL. The probability limits are asymmetric around the central line. Note that the probability limits vary with n_i.

In summary, probability limits are used to determine the odds of a physician falling outside the limits. For example, if a physician falls above the limit there is a 95 percent probability that the physician has a significantly higher percentage 'Excellent' than the overall percentage 'Excellent' for that question. The probability limits used in the report are similar to calculating the control limits using k=2 or 2σ.

Outline of a Model Report

The survey is designed to be analyzed under three main section headings: patient characteristics, accessibility profile, and visit satisfaction.

Patient Characteristics
This section of the report should include a summary of the demographic and other patient characteristic variables in the survey. Results are presented as percentages.

- Gender (Male, Female)
- Age (less than 17, 18-35, 36-64, greater than 65)
- Type of Visit (Scheduled, Walk-in)
- Payer type (Medicaid/Medical Assistance, Medicare, Health Maintenance Organization/Preferred Provider Organization/Other Prepaid, Private Insurance, Other, Self-Pay, and Worker Compensation/Motor Vehicle Insurance)
- Percentage excellent on question 10 "In general, would you say your health is"

Accessibility Profile
The survey contains three questions designed to assess the patient's perception of clinic's accessibility. The primary audience for this portion of the report is the clinic administrator or medical director. Each question is reported as the percentage of 'EXCELLENT' responses.

- Q1) How long you waited to get an appointment
- Q2) Convenience of the location of the office
- Q3) Getting through to the office by phone

Visit Satisfaction
The third section contains the results from the questions designed to measure the satisfaction with the provider for that particular visit. Each question is reported as the percentage of 'EXCELLENT' responses.

- Q4) Length of time waiting at office
- Q5) Time spent with the person you saw
- Q6) Explanation of what was done for you
- Q7) Technical skills (thoroughness, carefulness, competence of the person you saw
- Q8) The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw
- Q9) The visit overall

Level of Analysis

The level of analysis applied to each of these three sections should also be carefully considered to insure the clarity and brevity of the report to be distributed. Decision should be made regarding whether a question should be reported at the **clinic level**, **department level**, and/or the **physician level**.

Clinic-Level Comparisons

Compare the aggregate clinic results against the aggregate database results for all nine satisfaction questions and the patient characteristic variables. This provides a general overview of the departments measured by the clinic database during that data collection period. Generalization of these results across the entire health system should only be made after all clinic departments have been adequately sampled. These percentages can be easily tabled and graphed on two to three pages. Use the aggregate-level benchmarks provided in this report for comparison of clinic-level results.

- Patient Characteristics
- Visit Satisfaction
- Accessibility Profile

Department-Level Comparisons

Compare each clinic department to the like-specialty reference on the patient characteristics and overall visit satisfaction questions. This provides a department level summary of the patient mix seen and the satisfaction levels obtained by the entire department. The accessibility questions are typically not reported at this level because each department within a medical group is usually subject to the same accessibility factors and results would not vary beyond the clinic-level findings. Use the same specialty benchmarks provided in this report as a comparative benchmark.

- Patient Characteristics
- Visit Satisfaction

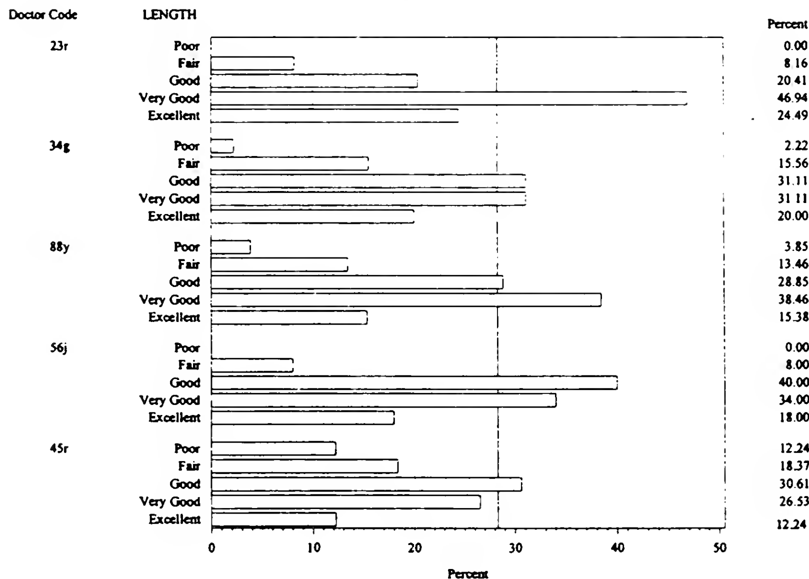
Physician-Level Comparisons

Report the six visit satisfaction questions at the provider level. For ease of comparison, all measured physicians within a specific department can be put on a single graph. For example, a graph for each question can be created that individually plots the results for the physicians practicing in the same department. The aggregate and the like-specialty results provided in this report can be used as a comparative benchmark. A detailed section of the physician results presents each patient's full range of responses (percentage of excellent, very good, good, fair, and poor) to the six visit satisfaction questions, (See page 12).

- Visit Satisfaction

Detailed Physician View

This section of the patient satisfaction report is designed to provide more detail to clinicians participating in this effort. The percentages for the entire range of responses for the six visit satisfaction question are presented. The figure below depicts the full range of responses for five General Surgery physicians from clinic XYZ to question 4 (The Length of Time Waiting). Furthermore, the vertical reference line indicates the entire database percentage excellent for the question.



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