Operational Policy Letter #45

Department of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

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CHANGES IN PHYSICIAN INCENTIVE PLAN REGULATION

I. 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 dates 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 (MCOs) with Medicare or Medicaid contracts or agreements must disclose information about physician incentive plans to HCFA or the State Medicaid Agencies. Those MCOs 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) is, for existing Medicare and Medicaid managed care organizations, the first renewal (or anniversary) date falling on or after January 1, 1997. We expect all MCOs 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 MCOs 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 MCOs 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 MCOs 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 27 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 MCOs 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 regulation will be sent separately. Medicare MCOs will also receive separate instructions from the Regional Offices concerning annual renewal notices and evidences of coverage for Medicare contracts.

II. CHANGES IN PHYSICIAN INCENTIVE PLAN REGULATION

A. 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 MCOs 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.

(1) 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.

(2) Determination of amount of stop-loss insurance:

The March final rule allowed two kinds of 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 organization 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 MCOs 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.

B. 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.

C. 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 MCOs 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:

Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Professional Limit
1 - 1000	$6,000*	$10,000*	$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
>25,000	none	none	none

NOTE REGARDING SMALL PATIENT PANELS: The asterisks 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 patients would likely not be adequate for panels of fewer than 500 patients.. MCOs 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.

D. THE TIMING OF DISCLOSURE

1) 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 an 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 MCOs 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 effective date for a new contract, without it.

To summarize, the following are the items in section 417.479 (h) that MCOs 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 toeither 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 HMOs, CMPs, HIOs and PHPs.

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 physician, 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, MCOs 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 MCOs 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.

(2) Reporting on Capitation Payments

The March rule requires that HMOs 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 annual 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.

E. 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 must 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 HMOs and CMPs will be required to do an annual beneficiary satisfaction survey as part of our monitoring of the quality of care furnished 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 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 HMOs and CMPs, as a condition of their contract with HCFA, to use the survey instrument developed under the auspices of the Agency for Health 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 MCOs that did not have a Medicare contract in place on or before January 1, 1996. Thus, MCOs that received an initial Medicare contract after January 1, 1996 and before January 1, 1997, do not have to comply with CAHPS, but do 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 MCOs 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 MCOs will need to disclose the summary of these surveys prior to the subsequent renewal or anniversary date and every year thereafter.

III. HCFA CONTACTS

MCOs with questions about any of the provisions in this OPL should direct their inquiries 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.