Operational Policy Letter #50

Department of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

March 19, 1997

OPEN ACCESS PHYSICIAN PANELS

Issue:

The Office of Managed Care, HCFA has been asked if Medicare-contracting HMOs and CMPs may be organized as an "open access" model managed care organization. The answer is yes, as long as all statutory and regulatory requirements regarding continuity of care and utilization management continue to be met.

Background:

We have been asked to approve a proposed arrangement wherein the Medicare contracting managed care plan allows its members to choose any physician on its Medicare contracted panel of providers to receive services at any time; and without prior authorization by either a primary care physician or "medical professional(s)" serving as a member of the plan's physician panel. This type of arrangement is being referred to as an "open access" model.

In the commercial managed care arena, we are seeing a relaxation of member rules that require stringent prior authorization for many health care services. We expect to see the same shift occurring for Medicare enrollment in managed care organizations. It is important to note that an open access model reflects the organizational structure of the managed care organization with regard to how members receive primary care and specialty care services and other plan benefits. The open access model is not a "product" and should not be confused with any product referred to as "point of service."

Discussion:

Although Federal law permits managed care plans to operate a primary care gatekeeper system, such an arrangement is not a Federal requirement. Consequently, HCFA neither requires nor prohibits the use of gatekeepers and similarly, neither requires or prohibits the lack of gatekeepers. Many Medicare contracting plans employ systems that permit specialist gatekeepers for beneficiaries who have special needs such as disabled

beneficiaries or those who are experiencing certain categories of disease. Other plans permit self-referral in-network options under certain circumstances. These arrangements often provide better access, continuity and coordination of care, as well as enhanced member satisfaction.

The arrangement for provision of services we discuss in this letter involves allowing enrollees access to any contracted physician on the plan's physician panel without going through a primary care physician.

Plans may operate this arrangement provided they do not conflict with the applicable provisions in Title XIII, applicable parts of the Social Security Laws, applicable portions of volume 42 of the Code of Federal Regulations and the HMO manual subject to the following considerations:

a. That the provision of basic health services is on a basis that is available and accessible with reasonable promptness with respect to geographic location, hours of operation and provision of after hours service depending upon the nature of care needed. Medically necessary emergency services must be available twenty-four hours a day, seven days a week. Also the contracting managed care organization must provide its services on a basis that ensures continuity in compliance with the provisions in 42CFR 417.106.

b. That the managed care organization does not relinquish the requirement that it provide or arrange for all basic health care services with the exception of medical emergencies.

c. That the managed care organization use the same or a subset of its non Medicare panel to provide Medicare covered benefits.

d. That the provision of health care by a non-physician must be supervised by a physician except for the services of physician assistants, nurse practitioners and clinical psychologists.

e. That the contracting managed care organization ultimately does not relinquish its authority to select a practitioner among those able to provide a given service. We interpret this requirement to mean, in this instance, that the managed care organization would nominate a suitable practitioner for its members who have no preference of the plan's panel of physicians they would see.

f. The managed care organization must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions.

g. The managed care organization must have an ongoing quality assurance program for its health services that stresses health outcomes and provides review by physicians and other health professionals of the provision of health services. It must be supported by an adequate system of health and medical records which accumulate performance and patient results, and which are adequately reviewed, interpreted and acted upon. Pertinent

medical information relating to the health care of Medicare enrollees must be readily available to plan-contracted medical professionals.

h. The managed care organization may not impose additional charges for open access or self-referral arrangements such as higher premiums or copays.

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