Medicare and Medicaid Managed Care

Beneficiary Purchasing:

A New Opportunity

1997

September 10, 1997

Capital Hilton Hotel

Washington, D. C.

The Health Care Financing Administration

Presents

"Beneficiary - Centered Purchasing:

A New Opportunity"

September 10, 1997
Capital Hilton Hotel
16TH & K Street, NW
Washington, D.C.

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Welcome

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

September 10, 1997

WELCOME TO CONFERENCE ATTENDEES:

It is with great pleasure that I welcome you to "HCFA Day" with the American Association of Health Plans. This conference provides HCFA and health plans with an excellent opportunity to cultivate partnerships and develop an understanding of how to better serve Medicare and Medicaid beneficiaries. Within the agency, we have entitled our effort "Beneficiary-Centered Purchasing."

HCFA developed the philosophy of Beneficiary-Centered Purchasing as a result of our recent reorganization. Our agency is, by far, the largest single purchaser of health care services in the country and, in this role, we believe we should focus on the Medicare and Medicaid beneficiaries on whose behalf we exercise our purchasing responsibility. As a public agency, we have a responsibility to emphasize not only the price, but the quality and accessability of health care. In this context, Beneficiary-Centered Purchasing means HCFA will use its purchasing power—in both capitated and fee-for-service programs—to turn market efficiencies to the advantage of Medicare and Medicaid beneficiaries. We do not interpret "purchasing" as simply a device for budget savings.

The Balanced Budget Act of 1997 and the HCFA reorganization represent major steps toward our goals. Our new organizational structure emphasizes the three major audiences: beneficiaries, States, and health plans and providers. I think you will find the new Center for Health Plans and Providers a valuable resource which will enhance communication between HCFA and health plans. The Balanced Budget Act, for its part, modernizes purchasing methods, streamlines operations, and expands benefits—real progress toward meeting beneficiaries' needs while improving program administration.

I hope you will find today's gathering informative in its specifics and enlightening in its description of our new course.

Sincerely,

Bruce C. Vladeck

American Association of Health Plans Welcome

As the Director for the new Center for Health Plans and Providers (CHPP), I want to welcome you to the annual HCFA Day in conjunction with the AAHP fall conference. We hope that today's program will help answer many questions that the recent organizational restructuring, as well as, the newly passed federal legislation, have generated.

The issues raised by these two events are numerous and complex; yet, not without merit. In order to make the Medicare and Medicaid programs their most effective, change is needed to compliment the new and emerging health care systems. We believe that, as providers of care, you can appreciate the need to grow in order to meet the requirements of a rapidly evolving medical marketplace.

Accordingly, Congress has mandated that our beneficiaries be given more medical care choices. These choices include such categories as varied managed care, fee-for-service, preferred provider organization, and medical savings account options. With these selections come substantial growth and, unfortunately, an interim period of 'growing pains' as HCFA and our contracted plans and providers adjust to the new opportunities.

Ultimately, we at HCFA, as well as you, our contracted plans and providers, answer to the beneficiary. We look forward to coordinating with you to offer the highest quality medical care to those we both serve.

Thank you for your participation and support in these challenging and exciting times.

Bruce Merlin Fried

American Association of Health Plans Welcome

Welcome and thank you for participating in HCFA Day at the American Association of Health Plans conference on "Reinventing Medicare and Medicaid: Solution for New Challenges." At the Center for Medicaid and State Operations, we are particularly enthusiastic about the changes taking place in the health care industry and look forward to working with all of you to meet the challenges associated with those changes.

The core work of HCFA's new Center for Medicaid and State Operations is to partner with states in beneficiary-centered purchasing of quality health care services to Medicaid beneficiaries. Operationally, this concept equates to providing enhanced access and accountability in a quality health care delivery system -- one that is affordable, effective, safe and fair. The system must support and respond to the individual's specific health needs and improve the beneficiaries' health status and satisfaction.

Our success in this work will require collaboration and open dialogue, not just with our state partners but with all those who are our stakeholders in the Medicaid program. Certainly you are an essential and growing component of that dialogue.

That is why we welcome this annual opportunity to learn from you, to communicate our plans and goals, and to further develop our shared commitment to quality health care for our nation's most vulnerable citizens.

These are exciting times indeed. Welcome aboard!

Sally K. Richardson

"HCFA Day"

Program Agenda

The Health Care Financing Adminstration

Presents

"Beneficiary - Centered Purchasing: A New Opportunity"

September 10, 1997 Capitol Hilton Hotel Washington, DC

8:30 - 9:00 a.m. **Registration of HCFA Day Guests**

9:00 - 9:15 a.m. **Greetings and Opening Remarks**
Program Moderator
Rondalyn S. Kane, Director
Office of Professional Relations

9:15 - 9:30 a.m. **Welcome**
Bruce Merlin Fried, Director
Center for Health Plans and Providers

9:30 - 10:15 a.m. **Legislative Update**
Implementation of the Balanced Budget Act of 1997 - Medicare Managed Care

Jean LeMasurier, Deputy Director
Plan & Provider Purchasing Policy Group
Center for Health Plans and Providers

Maureen Miller, Senior Policy Analyst
Division of Integrated Delivery Systems
Center for Health Plans and Providers

10:15 - 10:30 a.m. **Break**

10:30 - 11:15 a.m. **Legislative Update**
Implementation of the Balanced Budget Act of 1997 - Medicaid Managed Care

Donald Johnson - Acting Deputy Director
Office of Legislation

11:15 - Noon **Quality Improvement System in Managed Care (QISMC)**

QISMC is a quality improvement system for health plans which is being developed for the Medicare and Medicaid programs. Presenters will discuss the content and process of QISMC's development.

Dierdre Duzor, Director
Division of Quality System Management
Center for Medicaid and State Operations

Jeffrey Kang, M.D., M.P.H., Chief Medical Officer
Center for Health Plans and Providers

Noon - 1:30 p.m. **Lunch**

1:30 - 2:15 p.m. **The Balanced Budget Act of 1997 and HCFA's Research and Demonstration Agenda**

The Balanced Budget Act of 1997 has created a number of new demonstration initiatives to provide for exploration of new approaches, funding and health care delivery. This presentation will highlight some of these initiatives.

Lu Zawistowich, Director
Program Development and Information Group
Center for Health Plans and Providers

2:15 - 2:30 p.m. **Status Update**

Expedited Appeals Implementation
This presentation involves a discussion of the highlights of the expedited appeals process and the status of the implementation plans for the new HCFA requirement.

Raemalee Loen, Director
Ann Breslin, Plan Manager

Division of Program Management & Field Liaison, Team B
Health Plan Purchasing and Administration Group
Center for Health Plans and Providers

3:00 - 3:15 p.m. **Break**

3:15 - 4:45 p.m. **Status Update**

Current Significant Issues

This presentation describes the structure and functional responsibilities of HCFA's new operational components impacting Medicare's managed care contractors. Current significant issues related to the Medicare Managed Care Program will also be addressed.

Gary Bailey, Director
Health Plan Purchasing and Administration Group
Center for Health Plans and Providers

4:45 - 5:00 p.m. **Summation and Final Questions**

Gary Bailey, Director
Health Plan Purchasing and Administration Group
Center for Health Plans and Providers

Biographical Information

On

"HCFA Day"

Presenters

Gary Bailey
Director
Health Plan Purchasing and Administration Group
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Gary Bailey has served as Director of the Health Plan Purchasing and Administration Group (HPPA), Center for Health Plans and Providers (CHHPs) for the past nineteen months. Since the inception of the Medicare Managed Care Program, Mr. Bailey has served in top supervisory/management positions and as senior official in many important HCFA managed care components. He has served HCFA in other leadership capacities including Director of the Office of Beneficiary Access and Education.

Mr. Bailey received a Bachelor of Science in Business Administration from the University of Maryland and his Master's degree in Government Administration from George Washington University.

Anne Breslin
Plan Manager
Division of Program Management and Field Liaison
Team B
Center for Health Plans and Providers (CHHPs)
Health Care Financing Administration (HCFA)

Since 1990, Anne Breslin has worked at the Health Care Financing Administration (HCFA) in the office responsible for regulating health maintenance organizations. Currently, Ms. Breslin is a plan manager for several health plans on the west coast and she has been a project officer for the Medicare Managed Care Reconsideration Contract for the past five years.

Before joining HCFA, Ms. Breslin was a policy analyst in the Office of the Assistant Secretary for Management and Budget in the U.S. Department of Health and Human Services (DHHS). Prior to joining DHHS, Ms. Breslin worked on Capitol Hill as a legislative assistant for Congressman Michael Bilirakis of Clearwater, Florida and as a graduate intern for the U.S. House of Representatives Committee on Aging.

Ms. Breslin received her Master of Science in Social Administration from Case Western Reserve University and a Bachelor of Science from John Carroll University.

Deirdre Duzor
Director
Division of Quality System Management
Center for Medicaid and State Operations (CMSO)
Health Care Financing Administration(HCFA)

Deirdre Duzor is responsible for the development of policy concerning quality in the Medicaid program. During her tenure with HCFA, she has held several professional and management positions in HCFA's Medicaid Bureau.

In addition to her work with the Medicaid Bureau, Ms. Duzor served as the Director of Medicare Part A staff in HCFA's Legislative Office. She also served on the First Lady's (Hillary Rodham Clinton) Health Care Reform Task Force in 1993.

Prior to joining HCFA, Ms. Duzor held a variety of positions in the Office of the Secretary of the U.S. Department of Health and Human Services and in the Social Security Administration. Ms. Duzor has a Bachelor of Arts degree from Goucher College in Political Science and a Master of Arts degree from George Washington University in Social Policy.

Bruce Merlin Fried
Director
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Bruce Merlin Fried is Director of the Center for Health Plans and Providers within the Health Care Financing Administration (HCFA). As such, he is responsible for administering HCFA's policies and programs regarding health plans and providers, particularly as it relates to Medicare policy and operations. Mr. Fried also leads the agency's activities in program development and demonstration projects related to program change. Implementing HCFA's mission as a beneficiary-centered purchaser, Mr. Fried directs HCFA's major effort to maximize the value of care delivered by HCFA's plans and providers. He brings to the CHPPs more than 20 years of corporate, consulting, legal and political experience in health care policy.

From September, 1995 through June, 1997, Mr. Fried served as the Director of the Office of Managed Care where he worked to ensure that all Medicare and Medicaid beneficiaries enrolled in managed care received quality health care. Under his leadership, the intensity of oversight and monitoring of Medicare managed care plans was increased while the number of health plans and beneficiaries choosing managed care grew at a historic rate. While insisting that plans perform and ensuring that beneficiaries are protected, he also instituted several reforms to streamline the contract application process.

In addition, Mr. Fried has championed a purchaser's perspective throughout HCFA by focusing efforts on quality of care measurements and as a board member of the Foundation for Accountability (FAcct).

Mr. Fried brings to this office a long history of working for Medicare beneficiaries as well as broad health experience. From 1975 through 1981, he provided legal services to low income Floridians. While at Florida Legal Services, he was their chief representative in the state capitol. In 1981, Mr. Fried joined the National Senior Citizens Law Center, where he won new due process rights for Medicare patients and providers and secured confidentiality of Social Security recipients' tax filings. In 1986, he became the Executive Director of National Health Care Campaign where he built a nationwide political movement for health care reform.

In 1990, he was named the Executive Vice President of the Wexler Group, a prominent government relations firm, and provided counsel and representation on legislative and regulatory matters to a variety of corporate and association clients in the health care field.

Mr. Fried served as Chief Coordinator of the 1992 Clinton/Gore Campaign's Health Care Advisory Group. After the election, he was a member of the President's Transition Health Policy Team and coordinated the political, communications and public affairs activities.

Before coming to HCFA, Mr. Fried was Vice President for Federal Affairs of Family Health Plan (FHP) International Corporation, then one of the nation's largest health maintenance organizations. At FHP, he served as the senior corporate representative before Congress, regulatory agencies, trade associations, political groups and the media.

Mr. Fried received his Bachelor of Arts and Juris Doctor degrees from the University of Florida.

Donald Johnson
Acting Director, Office of Legislation
Health Care Financing Administration (HCFA)

Donald "Don" Johnson is currently Acting Deputy Director, Office of Legislation, HCFA. From 1989 to 1997, he was Director of the Medicaid Analysis Division of the Office of Legislation. Beginning in 1982 and culminating in 1989, Mr Johnson served a policy analyst in the Office of Legislation and prior to becoming a policy analyst, he was a budget analyst in HCFA's Budget Office.

Mr. Johnson received his Bachelor's degree from Cornell College, Mt.Vernon, Iowa and his Master's in Business Administration from Northwestern University, Evanston, Illinois.

Rondalyn S. Kane
Director
Office of Professional Relations
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Rondalyn S. Kane is Director of HCFA's Office of Professional Relations (OPR). She is responsible for developing and overseeing the implementation of communication strategies to inform professional organizations, public interest groups and private sector entities about programs and regulatory matters within the Health Care Financing Administration (HCFA). Ms. Kane works closely with agency leadership to develop and coordinate the dissemination of critical information to external organizations and to initiate and implement a national community outreach strategy that encompasses all associations, not for profits and other entities interested in national Health Care Policy. She is responsible for the collection of information from external organizations and the dissemination of that information to agency officials who utilize OPR's findings for program improvements and regulatory refinement.

Ms. Kane is a senior level policy professional with more than fifteen years of experience on Capitol Hill. She is versed in congressional relations, campaign management, the federal legislative process and public policy analysis. She received her Master in Public Administration from the University of Southern California and her Bachelor of Arts degree in Political Science from the University of Maryland Baltimore County.

Jeffrey Kang, M.D. M.P.H.
Chief Medical Officer
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Dr. Kang has served as Chief Medical Officer for the Center of Health Plans and Providers, formerly the Office of Managed Care, HCFA, since 1995. In that role, he deals with medical policy, purchasing initiatives and quality of care issues in the Medicare Program.

Serving as a White House Fellow during 1994-95, he was Special Assistant to Mr. Phil Lader, Administrator of the Small Business Administration. Coming to HCFA in 1995, Dr. Kang served for a period as Special Assistant to HCFA Administrator Bruce Vladeck.

Prior to joining the federal government, Dr. Kang was Vice Chairman of the Board and Chairman of the Complaint Committee for the Massachusetts Board of Registration in Medicine. During this time he worked on the Board's Quality Assurance and Peer Review Programs and developed new policies and regulations for nurse practitioners and for alternative dispute resolution.

His career began in 1984 at the Urban Medical Group in Boston, where he served as the organization's executive director and staff physician until 1994. During his tenure, the group participated in two capitated managed care programs for the elderly based on Secure Horizon's and on Lok/PACE models. He served as Medical Director for the Beth Israel Hospital/Tuffs IPA-HMO (1994), Board Member for the Bay State Health Care HMO (1992-93), Medical Director for Discharge Planning at Beth Israel Hospital (1991-92) and Medical Director of the Geriatric Care Unit at Brookline Hospital (1987-89).

He received his M.D. from the University of California, San Francisco, Master in Public Health from University of California, Berkeley and Bachelor of Arts from Harvard College.

Jean D. LeMasurier
Deputy Director
Purchasing Policy Group
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration

Jean D. LeMasurier is Deputy Director of the Health Plan and Provider Purchasing Policy Group. She is responsible for developing Medicare fee-for-service and managed health care policies affecting health maintenance organizations and other integrated delivery systems, hospitals, outpatient facilities, physicians, clinical laboratories, drugs and other providers of services.

Major areas of responsibility include development of standards and payment policies for health plans to enter a Medicare contract; development of the Medicare hospital prospective payment systems (PPS); and development of fee schedules for physicians. A major new responsibility is the development of policies to implement the Balanced Budget Act of 1997, including the **Medicare+Choice** Program (including the Provider Sponsored Organization (PSO) option) and the development of a prospective payment system for hospital outpatient services.

Ms. LeMasurier has almost twenty years experience with managed care programs, including responsibility for directing policy development and program improvement activities for the Medicare risk and cost contracting programs and the Federally Qualified

HMO Program in the Office of Managed Care, HCFA. She also was a project director for Medicare's first managed care demonstration projects and previously worked for the Senate Finance Committee, Subcommittee on Health.

Raemalee Loen
Director
Division of Program Management and Field Liaison
Team B
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Raemalee Loen originally served in the Department of Health Education and Welfare's (HEW) "Office of Health Maintenance Organizations" (OHMO). She was an active participant and took part in the early federal participation in HMO growth in the country. For the past eight years, after the merger of OHMO and the Medicare Managed care program, Ms. Loen has served in several supervisory positions in the areas of contract applications, program operations, and compliance monitoring. Ms. Loen received her Master's degree from the University of Southern California and a Bachelor's degree from the University of Maryland.

Maureen Miller, MPH, RN
Senior Policy Analyst
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Maureen Miller, MPH, RN, has been with the Health Care Financing Administration for nineteen years. She has worked in policy making positions where she helped bridge programmatic and political concerns. For the last eight years, Ms. Miller has served as a senior policy analyst with HCFA's Office of Managed Care and now the Center for Health Plans and Providers. She has worked on a broad range of federal and commercial managed care issues, such as emerging managed care products, organizational structures and Medicare program reforms. Currently, Ms. Miller is working on the negotiated rulemaking process for Physician Service Organization's (PSOs) solvency standards and will play a key role in policy development for Medicare Part C.

Lu Zawistowich, Sc.D.
Director
Program Development and Information Group
Center for Health Plans and Providers (CHPPs)
Health Care Financing Administration (HCFA)

Lu Zawistowich, Sc.D., is Director of the Program and Information Group, Center for

Health Plans and Providers, (HCFA). She is responsible for the development and implementation of Medicare delivery system and payment demonstration programs, plan and provider performance-based measurement systems and data systems for health plan management and fee-for-service prospective payment. Her previous position was as Director of the Office of State Health Reform Demonstrations(OSHRD) at HCFA where she directed the review, implementation, and evaluation of comprehensive state health care reform demonstrations projects. Prior to moving to OSHRD, Dr. Zawistowich was Deputy Director of HCFA's Office of Medicaid Policy. Her experience includes work on several health care reform task-forces and in the Maryland Medicaid Program. She received her doctorate in health policy and management from the John Hopkins University School of Hygiene and Public Health.

Legislative Update:

Medicare Managed Care

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

7500 SECURITY BOULEVARI
BALTIMORE MD 21244-1850

September 5, 1997

NOTE TO: All Medicare contracting health plans

SUBJECT: Medicare+Choice Program

Following is a brief description of recent legislative changes to the Medicare managed care program which may impact current contractors. The HCFA Center for Health Plans and Providers (CHPPs) will provide Medicare managed care contractors with additional information and guidance as policy decisions and statutory interpretations are made. We would urge current Medicare contractors to review this important legislation to determine how the provisions will affect various plan activities and objectives.

CONTRACTS WITH MEDICARE+CHOICE PLANS (Medicare Part C)

Public Law 105-33, The Balanced Budget Act of 1997, establishes a new authority permitting contracts between HCFA and a variety of different managed care and fee-for-service entities. The types of entities that may be granted contracts under this new authority include:

+ **Coordinated care plans,** including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.

+ **Religious fraternal benefit society plans** which may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees.

+ **Private fee-for-service plans** which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare fee schedule).

In addition to the above Medicare+Choice contractors, beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a **Medical Savings Account (MSA)** option. Under this option, beneficiaries would obtain high deductible health policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to $6,000. The difference between the premiums for such high deductible policies and the applicable

Medicare+Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses.

Current §1876 Contracts: Current HMO/CMP risk plans that remain in compliance with current contracting standards and comply with new requirements established under this statutory authority will automatically transition into the Part C Medicare+Choice program. Beginning January 1, 1998, section 1876 risk-based contractors will be paid under a new Medicare+Choice payment methodology rather than the current AAPCC method in section 1876(a), and will be subject to certain other Medicare+Choice provisions. Contracting standards for Medicare+Choice plans (except for PSO solvency standards) will be published by June 1, 1998 as interim final regulations. Upon publication, the Secretary will no longer accept new §1876 risk applications. As of January 1, 1999, existing §1876 risk-based contracts will be terminated, and plans in good standing will transition to the Medicare+Choice program.

Repeal of Cost Option: As of August 5, 1997, the Secretary is prohibited from entering into any new §1876 cost-based contracts, unless the plan is a Health Care Prepayment Plan with an agreement under section §1833 of the Social Security Act . The §1876 cost-based payment authority is repealed and all cost contracts are terminated as of December 31, 2002.

Limited HCPP Option: Beginning January 1, 1999, the Secretary may only contract with those HCPPs that are sponsored by Union or Employer groups, or HCPPs that do not "provide, or arrange for the provision of, any inpatient hospital services ...". This amendment will result in the termination of §1833 agreements with any organization that does not meet the new definition. HCFA will establish transition rules for §1876 risk-based contractors that currently receive reimbursement on a cost basis for enrollees remaining under a previous HCPP agreement.

§1876 Contracting Option for PSOs: During the transition, PSOs that are licensed by a State may be eligible organizations for purposes of obtaining a Medicare risk contract under section §1876. State licensed PSOs which apply for a risk contract would be required to meet all applicable standards for Competitive Medical Plans, except that the minimum enrollment requirements may be reduced or waived beginning January 1, 1998.

Medicare Subvention: The balanced budget amendment authorizes six (6) sites for a Medicare managed care subvention demonstration between HCFA and DoD. Under this demonstration DoD will be paid a reduced percentage of the Medicare+Choice reimbursement rate in return for providing Medicare covered services to eligible military retirees who are also eligible for Medicare. Enrollment is expected to begin in January of 1998, and for the first DoD managed care sites should begin providing health care services in February of 1998.

MEDICARE+CHOICE PROGRAM REQUIREMENTS

Unless otherwise noted, the following discussion is intended to summarize briefly only those statutory provisions which establish new Medicare+Choice program requirements, or amend existing contractual standards. New contractual standards will apply to §1876 risk plans which transition to the Medicare+Choice program for contract years beginning on January 1, 1999.

Beneficiary eligibility: Only beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in any Medicare+Choice plan that serves their geographic area. HCFA will promulgate rules to permit the continued enrollment of Part B-only enrollees in those §1876 risk-based plans that transition into the Medicare+Choice program.

According to rules to be determined by the Secretary, Medicare+Choice plans may allow beneficiaries who move out of the geographic area served by the Medicare+Choice plan to remain enrolled in the plan, provided those enrollees have reasonable access to the full range of covered services as part of the basic benefit package.

Contracting standards: By June 1, 1998, the Secretary will publish interim final regulations to establish standards for Medicare+Choice organizations. These standards will be based on existing requirements contained in Part 417 of the Public Health Title of the Code of Federal Regulations. All Medicare+Choice applications will be reviewed for compliance with the new standards, and §1876 risk plans that wish to transition to the Medicare+Choice option will be required to meet the contracting standards for contract years beginning January 1, 1999.

Federal standards will preempt any State authority with regard to benefit requirements, requirements relating to inclusion of or treatment by providers, and coverage determinations (including related appeals and grievance processes).

(NOTE: Fiscal solvency standards for PSOs will be established on a different track.)

Special Information Campaign: During November 1998 the Secretary will conduct an educational campaign to inform Medicare beneficiaries about the availability of Medicare+Choice plans, and plans with Medicare risk contracts. Current §1876 risk contractors must accept new enrollees during this period.

Enrollment: Beginning in November of 1999, the Secretary will provide for an annual national educational and publicity campaign to inform eligible beneficiaries about their Medicare+Choice plan options. Beneficiary plan choice is effective January 1 of the following year. Newly eligible enrollees who do not choose a Medicare+Choice plan are deemed to have chosen the original Medicare fee-for-service option, except that the Secretary may establish procedures under which "age-ins" enrolled in a contracting plan may be deemed to have elected the entity's Medicare+Choice plan.

Any beneficiary who is enrolled in a §1876 plan as of December 31, 1998 will be considered to be enrolled with that organization under the Medicare+Choice program if the plan is granted a Medicare+Choice contract beginning January 1, 1999.

Disenrollment: Starting in 2002, beneficiaries who are enrolled in a Medicare+Choice coordinated care plan will be able to disenroll from their elected plan option once during the first 6 months of 2002. Beneficiaries who enroll in a Medicare+Choice plan at the time they become eligible for Medicare will be permitted to disenroll at any time during the first year of enrollment.

Beginning January 1, 2003, beneficiaries may only disenroll from a Medicare+Choice coordinated care plan and choose another plan, leave Medicare fee-for-service to enroll in a Medicare+Choice plan, or return to Medicare fee-for-service, one time during the first 3 months of the calendar year. Beneficiaries will be effectively locked in to their Medicare+Choice plan election for the remaining nine months following this window. Exceptions to the lock-in period are available for enrollees under the following circumstances: the Medicare+Choice plan contract is terminated, the beneficiary leaves the plan service area, the Medicare+Choice plan fails to provide covered benefits or is found to be improperly marketing the Medicare product, or under other conditions specified by the Secretary.

Medicare+Choice plans may disenroll Medicare beneficiaries if it is determined that the enrollee was disruptive to plan operations, or failed to pay required premiums on a timely basis.

Coordinated Open Enrollment Period: In November 1999, the Secretary will hold the first annual coordinated open enrollment period to allow eligible beneficiaries to enroll in Medicare+Choice plans. Medicare+Choice plans will be required to submit comparative information to the Secretary.

Marketing Material Approval: If a Medicare+Choice plan's marketing materials were approved for one service area, they will be deemed to be approved in all of the plan's service areas, except with regard to area-specific information. Medicare+Choice plans are prohibited from giving monetary incentives as an inducement to enroll, and from completing any portion of the enrollment application.

Benefits: Public Law 106-33 establishes some new preventive benefits, and increases coverage for others. The updates to payment rates for current §1876 risk contractors and Medicare+Choice plans will reflect the costs of these new benefits.

BENEFIT	EFFECTIVE DATE
Annual Screening Mammography (for women over 40)	January 1, 1998
Screening PAP Smear and Pelvic Exam (every 3 years)	January 1, 1998
Colorectal Cancer Screening Exam	January 1, 1998
Bone Density Measurement (to rule out osteoporosis)	July 1, 1998
Prostate Cancer Screening Exam (for men over 50)	January 1, 2000

Disclosure: The Medicare+Choice plan must provide in a clear, accurate and standardized form certain information to each enrollee such as the plan's service area, benefits, number, mix and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, appeals and grievance procedures and quality assurance program. Upon request, enrollees must be provided comparative information, information on the plan's utilization control mechanisms, information on the number of grievances and appeals and their disposition in the aggregate and a summary of physician compensation arrangements.

Access to non-network providers: Medicare+Choice plans must cover services provided by non-network providers in the case of urgent care that is medically necessary when the enrollee is out of the plan service area, renal dialysis services for enrollees who are temporarily out of the plan's service area, and maintenance or post-stabilization care after an emergency condition has been stabilized.

Medicare+Choice plans are required to pay for emergency services without regard to prior authorization or the emergency provider's status as a network provider. An emergency medical condition is defined using a "prudent layperson" standard which may include the beneficiary's assertion of "severe pain".

QA Program: Medicare+Choice plans must undergo external quality reviews by independent review organizations. The Secretary is authorized to waive the external review requirement if the Medicare+Choice plan can demonstrate a record of excellence in meeting quality assurance standards, and compliance with other applicable requirements. Plans could be deemed to meet internal quality assurance requirements by becoming accredited by a private organization approved by the Secretary.

Providers: Medicare+Choice plans must establish procedures relating to physician participation in the plan, including notice of rules of participation, written notice of adverse participation decisions, and an appeals process. Medicare+Choice plans must consult with participating physicians regarding medical policy, quality and medical management procedures.

Medicare+Choice plans are prohibited from requiring contracting providers to indemnify the plan against actions resulting from the plan's denial of medically necessary care.

Plans may not restrict health care professionals' advice to enrollees regarding the beneficiary's health status or treatment options. The Act includes a "conscience protection" clause exempting a plan from being required to provide or cover a counseling or referral service if the plan (1) objects on moral or religious grounds, and (2) informs prospective enrollees of such policy before or during enrollment, and current enrollees within 90 days after adopting a change in such policy.

Minimum enrollment: Medicare+Choice plans will be required to meet the following minimum enrollment requirements: 5000 for HMOs, PPOs, and FFS plans in urban areas, and 1500 for PSOs; 1500 for HMOs, PPOs, and FFS plans in rural areas, 500 for PSOs. These requirements could be waived in the first 3 contract years.

The enrollment composition requirements, (known as the "50/50 rule") no longer counts Medicaid enrollees in the federal portion of the enrollment mix. The Secretary is given immediate explicit authority to waive the 50/50 requirement for contract years beginning January 1, 1997. The 50/50 requirement is repealed as of January 1, 1999.

Annual Audit: The Secretary must annually audit the financial records annually of at least one third of Medicare+Choice plans. The audit will include review of data related to Medicare utilization, costs, and computation of the ACR, and will be monitored by the GAO.

Plan User Fees: Medicare+Choice plans and section 1876 contractors must contribute their pro rata share, as determined by the Secretary, of estimated costs related to enrollment and dissemination of information and certain counseling and assistance programs. The Secretary is authorized to collect user fees but such fees are limited to $200 million in fiscal year 1998, $150 million in fiscal year 1999 and $100 million in fiscal year 2000 and beyond.

Payment: The 1998 payment rates for §1876 risk-based contracts and new Medicare+Choice plans will be announced on September 8, 1997. On **March 1**, beginning in 1998, the Medicare+Choice payment rates will be announced for the following contract year. In general, beginning in 1998 Medicare capitation rates to plans will be the greater of:

+ a blend of the input-price adjusted national rate and an area-specific rate, adjusted by a budget neutrality factor. The area-specific rate will be based on 1997 rates, and adjusted to reflect 1) a national average Medicare per capita growth rate, and 2) gradual removal of IME/GME costs;

+ a minimum payment amount of $367 for 1998, not to exceed 150% of the prior year rate, adjusted annually by a defined update factor; or

+ a minimum percentage increase (2% per year).

The 1997 capitation rates (from the 1997 AAPCC ratebook) will be the base for (1) the area specific rates in the blend and (2) the minimum percentage increase rates. In an area where the 1997 AAPCC varies by more than 20 percent from the 1996 AAPCC, the Secretary can substitute for the 1997 rate a rate more indicative of the cost of enrollees in the area.

The update factor for the area specific rates in the blend and the minimum payment amount will be the national average per capita Medicare+Choice growth rate, reduced by 0.8 percentage points for 1998, and 0.5 percentage points for 1999 through 2002, and 0.0 percentage points thereafter.

The payment area is the county or equivalent area specified by the Secretary. Beginning in 1999, states would be able to request a statewide payment rate, or rates based on Metropolitan Statistical Areas and a statewide rural area. Such changes would be subject to a budget neutrality requirement.

Reporting of Encounter Data: Beginning January 1, 1998, the Secretary will require that current Medicare managed care contractors submit hospital encounter data covering the period beginning July 1, 1997. Beginning on or after July 1, 1998, the Secretary has the authority to establish other encounter data reporting requirements for Medicare+Choice plans, including current §1876 risk contractors that transition to the new program on January 1, 1999.

Premiums: Beginning in 1998, by May 1 all Medicare+Choice coordinated care plans including HMOs, PSOs, and PPOs must submit adjusted community rate (ACR) proposals for basic and supplemental benefits, the plan's premium for the basic and supplemental benefits, a description of cost sharing and the actuarial value of cost sharing for basic and supplemental benefits and a description of any additional benefits and the value of these benefits.

State taxes: States may no longer tax the premium revenue of Medicare+Choice plans.

Provision of Information: As part of the monitoring and compliance process, Medicare+Choice plans must disclose financial information to demonstrate fiscal soundness, including data related to business transactions concerning property transfers and trades, loans, and extensions of credit.

Please see the attachment for additional information regarding implementation deadlines. While CHPPs staff is available to assist plans with specific implementation issues and questions, it is important for all Medicare contractors to study the legislative language in order to ascertain how these changes will affect your operations.

Sincerely,

Bruce Merlin Fried
Director

Attachment

September 3, 1997

NOTE TO: Risk Sharing Organizations and Other Interested Parties

SUBJECT: Update to 45-Day Announcement To Reflect P.L. 105-33,
The Balanced Budget Act of 1997

On July 24, 1997, the Center for Health Plans and Providers and the Office of the Actuary released the annual 45-day notice, which announces any changes in the AAPCC methodology and any benefit coverage changes. This notice was released prior to enactment of P.L. 105-33, the Balanced Budget Act of 1997, and cautioned that pending legislation, if enacted, could substantially affect the determination of Medicare's managed care payment rates for 1998 as well as the program's required benefit coverages. The purpose of this memorandum is to advise plans of the primary changes in methodology and benefit coverages resulting from P.L. 105-33.

Methodology changes

The procedure for calculating Medicare payments to at-risk managed care plans is fundamentally changed under P.L. 105-33. The payments are no longer linked directly to local fee-for-service costs under Medicare and are, instead, based on a blend between current local area payment rates and an overall national average. The new procedure is complex and is outlined in the enclosed summary document. This summary should be used as a general guide only; reference should be made to section 4001 of P.L. 105-33 for details.

The July 24 notice announced a recalculation of the demographic factors used in developing the standardized county AAPCC amounts and for adjusting payments to plans to match their enrollee characteristics. It was intended that these updated factors would be used in calculating the AAPCCs for 1998. We also anticipated that the updated factors could be used with any new payment methodology that might be enacted. However, as a consequence of specific provisions of P.L. 105-33, we must revert to the old factors for the 1998 payment rate calculations. Under the old law, (1) standardized payment rates were determined for each county by removing the effects of demographic variations in costs, and (2) payments to plans were adjusted to reflect the demographic characteristics of the plan's enrollees. Both steps were necessary to avoid inconsistencies in payments. The new law does not provide for restandardizing the initial county payment levels to reflect the new demographic factors. Use of the new factors for purposes of adjusting payments to plans, without restandardizing, would result in an inconsistent application of the demographic adjustments and would have an unintended and arbitrary effect on payment rates. In addition, the new legislation requires the implementation of a new, more comprehensive system of risk adjustment by the year 2000. Accordingly, little would be gained by introducing significant changes at this time through revised demographic factors. Instead, we will continue to study the various risk adjustor methodologies in order to determine the most appropriate system to implement in 2000.

As previously announced in an Operation Policy Letter (OPL) on July 24, HCFA will implement a more precise definition of institutional status for plan enrollees, which would exclude such entities as board and care facilities, that do not provide the same level of care and are not considered "institutions" for Medicare purposes. This change is fully consistent with P.L. 105-33. Accordingly, the new definition will be used as previously announced. The OPL also reiterates that an enrollee must have been a resident for a minimum of 30 days to qualify for the higher level of payment, a policy that has been in effect for many years.

New benefit coverages

P.L. 105-33 expands Medicare's benefit coverage provisions to include several new preventive and "screening" services. The following summary of these new coverages was extracted from the Internet site maintained by the House of Representatives' Committee on Ways and Means. (The term "agreement" refers to the conference agreement on H.R. 2015, subsequently enacted into law as P.L. 105-33.) Once again, reference should be made to the appropriate provisions of P.L. 105-33 for an authoritative statement of these coverages.

Screening Mammography. Effective January 1, 1998, the agreement would authorize coverage for annual screening mammograms for all women ages 40 and over. It would also waive the deductible for such mammograms.

Screening Pap Smear and Pelvic Exams. Effective January 1, 1998, the agreement would authorize coverage, every three years, for a screening pelvic exam which would include a clinical breast examination. Coverage for both Pap smears and screening pelvic examinations would be authorized on a yearly basis for women at high risk of developing cervical cancer and for women of childbearing age who have not had a test in each of the preceding three years that did not indicate the presence of cervical cancer.

Prostate Cancer Screening Tests. Beginning January 2000, the agreement would authorize an annual prostate cancer screening test for men over age 50.

Coverage of Colorectal Screening. The agreement would authorize coverage of colorectal cancer screening tests. A test covered under the agreement would be any of the following procedures furnished for the purpose of early detection of colorectal cancer. (1) screening fecal-occult blood test, (2) screening flexible sigmoidoscopy, (3) screening colonoscopy for high-risk individuals, and (4) other procedures the Secretary finds appropriate for the purpose of early detection of colorectal cancer. The Secretary would be required to make a determination about whether to cover barium enema screening within 90 days of enactment.

Diabetes Screening Tests. Effective July 1, 1998, the agreement would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting meeting certain quality standards. In addition, the agreement would extend Medicare coverage of blood glucose monitors and testing strips to

Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organizations). The agreement would also reduce the national payment limit for testing strips by 10 percent beginning in 1998.

Bone Density Measurement. Effective July 1, 1998, the agreement would provide bone density measurement screening for certain Medicare-eligible women at high risk for osteoporosis.

Comments or questions about the information in this notice may be addressed to:

Mr. Sol Mussey
Health Care Financing Administration
Director, Division of Medicare and Medicaid Cost Estimates
N3-26-00
7500 Security Boulevard
Baltimore, Maryland 21244

Sol Mussey

Enclosure--New Methodology for Developing Managed Care Payment Rates

New Methodology for Developing Medicare Managed Care Payment Rates *

The following is a brief description of how the Medicare payment rates for managed care organizations will be calculated based on the provisions in the Balanced Budget Act of 1997 (P.L. 105-33). The payment rates will be developed for aged, disabled and ESRD beneficiaries separately. The methodology for the three groups is the same, with some minor differences, (e.g., ESRD payment rates are calculated on a statewide basis).

1. The new calculation starts with the 1997 standardized county rates as a base. The law does not stipulate any adjustment to this base, other than to "carve out" a specified portion of the rates which are for medical education expenses. For 1998, this means carving out 20 percent of the medical education cost (both graduate medical education and indirect medical education) implicit in the 1997 base rates. The law also permits the substitution of a more representative rate for areas where the 1997 rate varied by more than 20 percent from the 1996 rate.

2. The 1997 base rates for Parts A and B combined (adjusted as in step 1) will be inflated by the national average per capita Medicare growth rate less an amount specified in the law. This is essentially a USPCC increase reduced by 0.8 percent for 1998. This step defines the "area specific rates" for each county.

3. Blended payment rates will be based on proportions of local and national rates defined in the law. To calculate the blended formula amounts, a "national average input-price-adjusted amount" is determined for each county. First, a national average rate will be calculated as a weighted average of the area specific amounts, using the product of the total Medicare enrollment in the county times the average demographic factor for the county as the weights. This national average will be separately calculated for Part A and Part B. Second, the two national averages will be input-price-adjusted for each county. For Part A, 70 percent of the amount will be adjusted by the area hospital wage index. For Part B, 66 percent of the amount will be adjusted by the geographic practice cost index for physicians, and of the remaining 34 percent, 40 percent will be adjusted by the hospital wage index. Finally, once the input-price-adjusted national average is calculated for both Part A and Part B in each county, the two will be added together to get a combined Medicare input-price-adjusted national average for the county. This input-price-adjusted national average amount for the county will be used with the area specific rates for the county to calculate the blended payment amount.

4. The blended amounts for 1998 are 90 percent of the area specific rate plus 10 percent of the national input-price-adjusted amount for the county.

5. The preliminary payment rate in 1998 for the county is now the larger of:

    a. The blended amount for the county;

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*Note: This description is a very brief summary of a complex subject. It should be used only as an overview and general guide to the new payment rate calculations. Reference should be made to the appropriate sections of P.L. 105-33 for authoritative guidance.

b. The 1997 standardized county rate (as published in the 1997 rate book) increased by 2 percent; or

c. $367 (or, if lower, 150 percent of the 1997 standardized rate for areas outside of the 50 States and the District of Columbia.)

6. Once the preliminary payment rate is determined for each county, as described in step 5, a "budget neutrality adjustment" is required to determine the final payment rates for each county. This adjustment provides that the aggregate payments that are estimated for 1998 using the greater of the blends, minimum increase, and floor must be equal to the aggregate payments that would be made if payments were based solely on the area specific rates. The budget neutrality adjustment would be made only to the county rates based on the blended formula. If the budget neutrality adjustment would lower a county rate to a point such that the minimum increase or floor amount is now larger, the county rate would be set at the minimum increase or floor, respectively.

7. After the budget neutrality adjustment is made and the final county rates are determined, the county rates will be separated into Part A and Part B amounts based on the relative weights of Part A and Part B services for total benefits on a national level.

The methodology for years after 1998 is essentially the same. The carve out for medical education increases 20 percentage points per year until it is completely removed. The blended formulas shift 8 percentage points from the area specific to the national rate each year until it reaches a 50/50 split. The annual increase in the area specific rates and the floor amount is indexed in future years to the national average per capita Medicare growth rate, i.e. the USPCC increase with an adjustment of -0.5 percentage point for each year 1999 through 2002. These factors are summarized in the table below. In addition, beginning with the rates for 1999, adjustments will be made to compensate for differences between actual and estimated Medicare growth rates used in the 1998 and later calculations.

Calendar Year	Growth rate: USPCC increase less	Medical education carve out	County/national blending percentage
1998	0.8%	20%	90%/10%
1999	0.5%	40%	82%/18%
2000	0.5%	60%	74%/26%
2001	0.5%	80%	66%/34%
2002	0.5%	100%	58%/42%
2003 and later	0.0%	100%	50%/50%

Office of the Actuary
Health Care Financing Administration
September 3, 1997

Fact Sheet

On

Quality Improvement System

For

Managed Care (QISMC)

QUALITY IMPROVEMENT SYSTEM FOR MANAGED CARE (QISMC)

The objective of this project is to design a new approach to the oversight of the quality of care delivered by Medicare and Medicaid managed care plans. Historically, HCFA's and States' reviews of managed care plans have focused on structural standards that have looked at a plan's infrastructure and **capacity** to improve care, as opposed to looking at whether the plan actually improved care. In the meantime, HCFA, States, and other purchasers of managed care are increasingly demanding performance measures to hold managed care organizations "accountable." QISMC will define the relationship between these two oversight tools and additional tools used in the oversight of quality of care.

For plans, QISMC will define and elaborate what HCFA's expectations are with regard to their internal quality assessment and performance improvement. The expectation will shift away from reviewing whether plans have the infrastructure to improve care to an emphasis on demonstrable and measurable improvement. The question is not whether plans are able to improve, the question is whether they did improve. Here HCFA will have to address how to ascertain improvement, assess statistical and programmatic significance, and define the number of studies needed to evidence improvements in care. QISMC will define in advance for plans what is acceptable demonstrable and measurable improvement. These definitions will also serve as the basis for HCFA reviewers to monitor plans performance and compliance based on data.

For purchasers, including HCFA and Medicaid agencies, QISMC will elaborate on the "tools" available and develop a strategy for purchasers to use to improve the care of their beneficiaries. Purchasers have a responsibility to use available data and to work with plans to improve the quality of care they deliver. Such tools include: standards, publishing data, technical assistance and collaborative quality improvement projects, and rewards for good performance. Traditional reviewer tools which emphasized structure will need to be re-evaluated with respect to the "new" emphasis on demonstrable and measurable improvement. However, there will be some structural elements that performance measurement cannot replace. QISMC will explore the relationship between the two types of reviews (structural versus measurable improvement) and give specific guidance as to how purchasers will use performance measurement to improve care.

HCFA has contracted with the National Academy for State Health Policy (NASHP) to conduct this project. NASHP under previous contracts with HCFA, performed related work for both Medicare and Medicaid. In 1993 the Academy worked with HCFA in designing QARI (Quality Assurance Reform Initiative) which were guidelines to States, and in 1995 the Academy reviewed and compared Medicare quality standards against other public and private entities' standards. The contractor's current scope of work includes the specification on an organizational framework for Medicare and Medicaid quality oversight, development of unified standards, reviewer guidelines, and convening a "Quality of Care Group" made up of representatives of plans, consumers, and state/federal regulators to advise and oversee the contractor's work. Additional expert individuals, organizations, and government components will be included in the review process. The project will be completed in 1998.

Demonstrations

Health Care Financing Administration

Center for Health Plans and Providers, Program Development and Information Group

The following demonstrations are in varying stages of development:

- Federally Qualified Health Centers
  Contact: Vic McVicker - 410-786-6681

- Department of Defense/Veterans Administration Subvention
  Contact: Ron Lambert - 410-786-6624

- Competitive Pricing
  Contact: Ron Deacon - 410-786-6622

- Group Volume Performance Standards
  Contact: Teresa DeCaro - 410-786-6604

- Coordinated Care
  Contact: Catherine Jansto - 410-786-7762
  Teresa DeCaro - 410-786-6604

- Competitive Bidding for Part B Services
  Contact: Herb Silverman - 410-786-7702

Expedited Review Process For Medicare Beneficiaries Enrolled in Health Maintenance Organizations

September 10, 1997

NOTE TO HCFA BENEFICIARY CENTERED PURCHASING CONFERENCE ATTENDEES

Attached for your information is a copy of the Questions and Answers section of the July 22 Program Memorandum regarding the Expedited Review Process for Medicare Beneficiaries Enrolled in Health Maintenance Organizations. This Program Memorandum is part of the implementation of the final rule published in the Federal Register on April 30. Highlights of the regulation and the implementation process are as follows:

o The April 30 regulation establishes a 72-hour expedited review process for two types of beneficiary issues; 1) organization determinations regarding services, and 2) appeals of health plan decisions not to approve or provide care which the beneficiary feels is covered by Medicare. This expedited process supplements the standard 60-day maximum time frame for processing initial determinations and appeals. After the 72-hours or 60-days for HMO appeals processing, cases where health care or payment is denied must be sent to the HCFA contractor, the Center for Health Dispute Resolution.

o Beneficiaries and their appointed representatives may file an appeal, a non-plan provider may file an appeal if he/she completes a waiver of payment statement. Plan physicians do not have appeal rights except as an appointed representative.

o Reviews must be expedited if the standard process time frames could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

o The HMO makes the decision whether or not a beneficiary's request to expedite a case is granted with one exception: beneficiary appeals must be expedited when supported by a physician or filed by a physician as a beneficiary's appointed representative. Cases which are not expedited must go into the standard appeals process.

o Beneficiaries have the right to present evidence during both the standard and expedited review periods. Evidence may be presented in any reasonable manner such as in person, by telephone or FAX.

o HMOs must comply with this regulation as of August 28. HMOs were required to notify Medicare enrollees of the expedited 72-hour organization determination and appeals process by letter or other written communication such as an article/insert in a newsletter. HMO documents such as Evidences of Coverage may be amended by an insert until December 31 after which time all plan documents must incorporate approved language.

o HCFA has held three conferences to provide information on the expedited review process, two more are scheduled: New York on September 15-16 of this month and Denver on the 30th.. Further follow-up such as a Program Memorandum of conference-generated Q & A is planned.

Questions and Answers for Health Plans Regarding:
The Final Rule With Comment titled:
The Medicare Program: Establishment of an Expedited Review Process
for Medicare Beneficiaries Enrolled in HMOs, CMPs and HCPPs

1. **By what date must health plans be in compliance with the new expedited review processes?**

August 28, 1997.

2. **When and how must we inform enrollees of their expedited review rights?**

In order to comply with the new regulations health plans must notify Medicare enrollees of the expedited/72-hour organization determination and appeal processes prior to August 28. You may notify enrollees through a special letter, an article/insert in a news letter or other health plan publication directed to the Medicare enrollee. **In addition, health plan documents (such as Evidence of Coverage, Member Handbook, etc.) that provide Medicare beneficiaries with information about their appeal rights must be amended.** Until December 31 or until the next printing--whichever comes first--the current description of appeal rights must be amended by an insert which describes the expedited process for organization determinations and appeals. Beginning January 1, 1998, all health plan documents must incorporate approved language which describes the expedited organization determination process as well as the expedited reconsideration process. All Notices of Noncoverage (NONC) and all denial notices must be revised by **August 28.**

3. **Is Model Appeal language available?**

Yes. In order to hasten approval of new HMO appeals language through the HCFA Regional Office and state authorities, we provided Model Appeal Language in the June 18, 1997 Program Memorandum. This language has been revised and is replaced by the separate Model Appeal Language for Claim Denials and Service Denials provided in the July 1997 Operational Policy Letter. Use of this language will facilitate approval by early August and thus meet HCFA requirements for having this information in place.

4. **Will HCFA provide training for health plan staff?**

Yes, HCFA plans to hold training sessions in various parts of the country. These sessions are in San Francisco on August 21, Chicago on August 25, and New York in September (date to be determined).

5. Who can request an appeal (Standard 60-day or Expedited 72-hour)?

1. An enrollee may file an appeal.

2. If an enrollee wants someone to file the appeal for him or her:

a. The enrollee should provide his/her name, Medicare number, and a statement which appoints an individual as his/her representative. (Note: The enrollee may appoint any provider.)

For example: "I [*enrollee*] appoint [*name of representative*] to act as my representative in requesting an appeal from [*name of HMO*] and/or the Health Care Financing Administration regarding *[name of HMO]'s* (denial of services) or (denial of payment for services). **NOTE: Denial of payment for services may only be appealed under the Standard 60 day appeal process.**

b. The enrollee must sign and date the statement.

c. The enrollee's representative must also sign and date this statement unless he/she is an attorney.

d. The enrollee must include this signed statement with his/her appeal.

3. A non-plan provider may file a standard appeal for a denied claim if he/she completes a waiver of beneficiary payment statement which says he/she will not bill the enrollee regardless of the outcome of the appeal.

4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law may file a standard or expedited appeal.

6. What other authority does a representative of a beneficiary have?

On behalf of a beneficiary, a representative may:

(1) Obtain information about the beneficiary's claim to the same extent that the beneficiary is able to.
(2) Submit evidence;
(3) Make statements about facts and law; and
(4) Make any request or give any notice about the proceedings.

7. Does the expedited appeal regulation extend appeal rights to plan physicians and providers?

No. However, plan physicians and providers may be appointed representatives by beneficiaries or may provide statements in support of a beneficiary's request for an expedited appeal.

8. **Does the expedited appeal regulation change the requirement that requests for standard 60 day appeals be filed in writing?**

No. Requests for standard 60-day appeals must be filed in writing. If an enrollee orally requests a standard 60-day appeal, instruct him/her to file a written request and indicate where it should be sent. The standard 60-day appeal process requires that appeals be requested in writing. However, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in the standard 60 day process. You are required to document oral requests for expedited appeals in writing.

9. **What is an expedited organization determination?**

Normally health plans have 60 days to process a Medicare enrollee's request for a service. In some cases, enrollees have a right to an expedited/72-hour organization determination. An enrollee can get an expedited organization determination if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 60-day organization determination process.

10. **What is an expedited appeal?**

Normally health plans have 60 days to process a Medicare enrollee's appeal. In some cases, enrollees have a right to an expedited/72-hour appeal. An enrollee can get an expedited appeal if his/her health, life, or ability to regain maximum function may be jeopardized by the standard 60-day appeal process.

11. **Does an enrollee have to have an expedited organization determination in order to get an expedited appeal?**

An expedited determination is not a prerequisite to an expedited appeal. An expedited appeal may be granted even if the organization determination proceeded through the standard 60-day process. A request for an expedited appeal must be considered independently from a request for an expedited organization determination and may be granted even if the request for expedited organization determination is denied.

12. **If an enrollee requests an expedited review and supports the request with a letter from a physician noting the urgent need for the services, is the health plan obligated to process the request in the expedited 72-hour process?**

Yes. In this example, the beneficiary has filed the request for expedited review (organization determination/ reconsideration (appeal)). Because there is physician support, the expedited review must be conducted. Health plans are not permitted to turn down a physician's request for an expedited review on behalf of an enrollee, or to turn down an enrollee's request for an expedited review when it is supported by a physician.

13. **Under what circumstances may a health plan turn down a physician's request for an expedited appeal?**

A) Health plans should not process enrollee and physician requests for an expedited appeal regarding hospital discharge if an immediate PRO review for hospital discharge is being conducted.
B) Health plans are not required to grant a physician's request for expedited review when the request concerns a denial of payment.

14. **What can be appealed?**

Medicare enrollees can appeal if they do not agree with *[name of HMO or name of medical group]* decisions about their health care. **They have a right to appeal if they think:**

- *[name of HMO or name of medical group]* has not paid a bill
- *[name of HMO or name of medical group]* has not paid a bill in full
- [name of HMO *or name of medical group]* will not approve or give him/her care that should be covered
- *[name of HMO or name of medical group]* is stopping care that he/she still needs.

NOTE: The 72-hour appeal process does not apply to denials of payment.

15. **Is hospital discharge subject to the expedited appeal process?**

The June 18 Program Memorandum indicated that the Hospital NONC must include the immediate PRO review right as well as the standard and expedited appeal processes. We wish to clarify that enrollees who are inpatients at a hospital would be well advised to use the immediate PRO review process if they disagree with a discharge decision. However, if an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee may still request an expedited review. Medicare contracting health plans should not process any requests for expedited appeal when immediate PRO review is being conducted for hospital discharge.

16. **Is a denial based on exhaustion of benefits appealable?**

Yes. Exhaustion of a benefit is a termination which is an appealable organization determination. Depending on the circumstances, this appeal may fall under either the standard or expedited appeal process.

17. **Is a physician who orally requests an expedited review on behalf of an enrollee required to obtain a signed statement from the enrollee authorizing the representation?**

Yes. Health plans must be able to document that a request for appeal is valid. Therefore, representative statements are required every time a beneficiary appoints someone to act on his/her behalf on appeal. This representative designation is valid throughout all levels of the appeal process for the appeal case. Representative statements must be provided to the health plan. The health plan is expected to commence its review prior to receipt of the statements. However, the health plan is not obligated to issue a determination prior to receipt of the statement.

18. **Is a representative statement required of physicians who support a beneficiary's request for expedited appeal?**

No. Physician calls, FAXES etc. in support of a beneficiary's request for expedited review do not require a representative statement. In cases where the physician is supporting a request, the beneficiary is responsible for filing the appeal request by phone, by FAX, in person or by mail. If you have not yet heard from the beneficiary contact the beneficiary to document the beneficiary's appeal.

19. **Can a health plan designate the office or department within its organization where requests for expedited review are to be made?**

Yes. Health plans are required to develop a meaningful process for receiving requests for expedited appeals that may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and health plan receipt of requests for expedited reviews. These procedures must be clearly explained in member materials including denial notices and NONCs. In addition, health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the designated health plan office or department.

20. **Who makes the decision to expedite?**

Health plans have the responsibility for deciding whether or not an enrollee's request for expedited review is granted with the following exception: If a physician files the request as a representative of the enrollee or files a statement orally or in writing in support of a request by a beneficiary, the health plan must conduct an expedited review.

21. **What happens when we deny a request for expedited organization determination or appeal?**

When a request for expedited organization determination or expedited appeal is denied, the health plan must automatically transfer it to the standard 60-day process for review. The health plan may not request that the enrollee file a written appeal. The standard time frame begins with the date the health plan receives the request for expedited review.

22. **How and when do we inform the enrollee of the decision to deny an expedited review?**

When the health plan denies a request for expedited review, it must notify the enrollee orally at once and follow-up with a written letter of explanation within 2 working days. The plan must include in this letter an explanation that the enrollee's request will be processed within 60-days and that if the enrollee disagrees with the decision to deny an expedited review, the enrollee may file a grievance with the health plan. The health plan must provide instructions and the time frame for the grievance process.

23. **Does the enrollee have a right to appeal a health plan decision to deny an expedited review?**

No. However, the enrollee may file a grievance with the health plan. The health plan must provide instructions to its enrollees regarding this right including the time frame for the grievance process.

24. **How can health plans give enrollees an opportunity to present evidence during the 60-day and the 72-hour expedited review process?**

Health plans must give the enrollee an opportunity to present evidence during the standard and expedited review periods. Health plans must inform enrollees of this right when the enrollee makes the request for an appeal. The health plan must allow the enrollee to present this information in any reasonable manner, including in person, by telephone and by FAX.

25. **Are there any circumstances under which the health plan could request an extension of the 72-hour time frame?**

An extension of up to 10 working days is permitted if requested by the enrollee or if the HMO or CMP finds that additional information is necessary and the delay is in the interest of the enrollee. Examples of reasons for an extension include additional diagnostic testing or consultations with medical specialists or a beneficiary request for the extension in order to provide the health plan with additional information. HMOs are not permitted to use the extension to gather information from contracted providers, HMOs must have internal mechanisms for gathering information from contracted providers within the 72-hour timeframe.

26. **How is the 10 day extension obtained?**

If the beneficiary needs an extension of up to 10 days, he/she orally informs the health plan and explains to the health plan why he/she feels the extension is necessary. Health plans must document beneficiary requests for extensions in writing.

If the health plan needs an extension of up to 10 days, the health plan orally informs the beneficiary and explains to the beneficiary why the health plan feels the extension is necessary, how the extension will benefit the beneficiary and when the decision will be made. Health plans must follow-up with the beneficiary in writing.

27. **Are there any circumstances under which the health plan could request an extension greater than 10 working days.**

No. However, in a specific circumstance, the elapsed time period for a plan decision may exceed 10 working days. In this circumstance, if the health plan has requested information from non-affiliated physicians or other providers, the regulation provides that the plan's decision must be made within 72-hours of receipt of the requested information. As the information might be received on the 10th day, the time period could exceed 10 working days.

Note: No extension of time will be permitted if network providers have failed to submit information required by the health plan.

28. **Is there an expedited process for the Administrative Law Judge Level and beyond?**

No, the expedited processes only apply to the HMO level reconsideration and the HCFA level reconsideration.

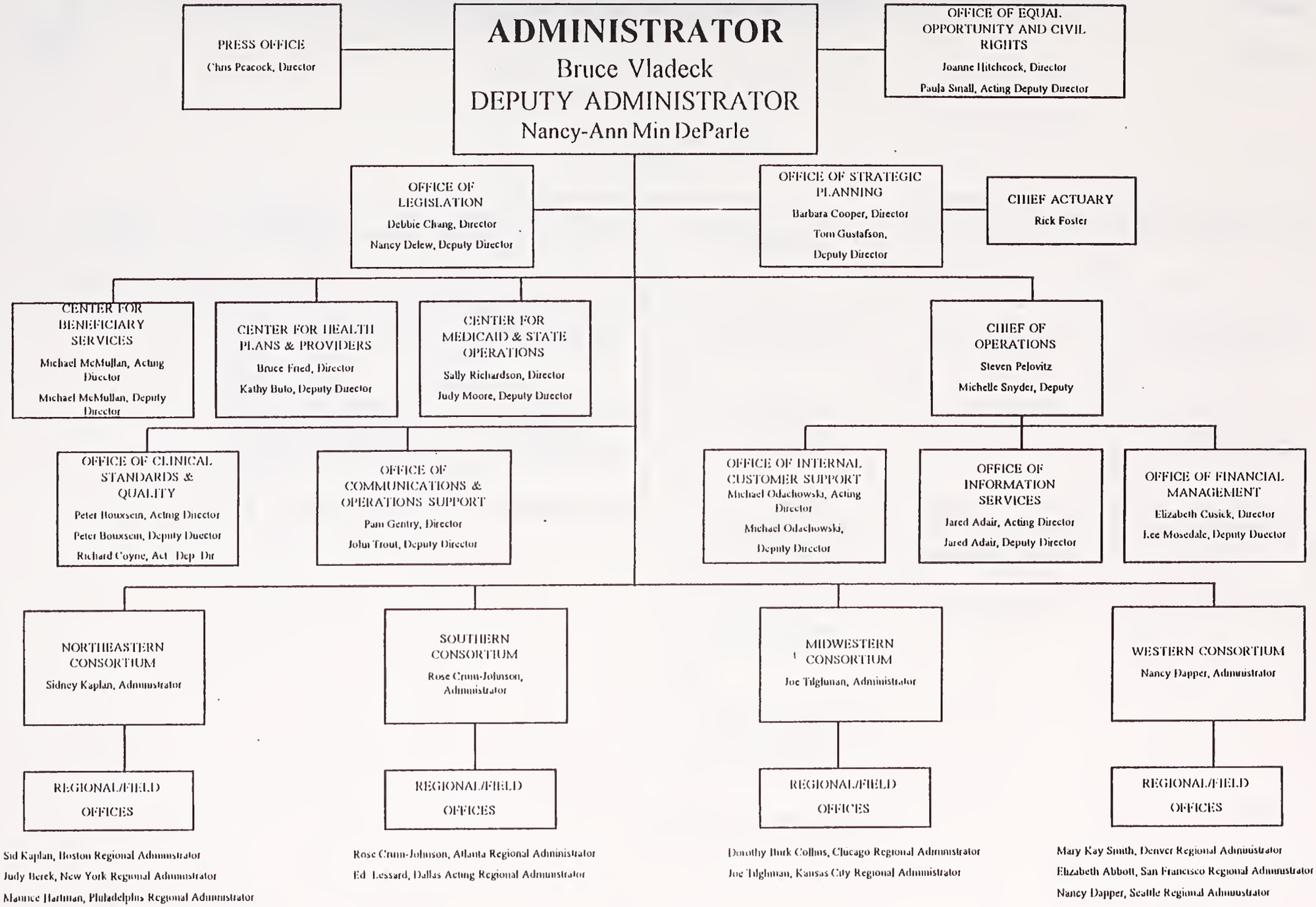
The Health Care Financing Administration

Organizational

Chart

HCFA ORGANIZATIONAL STRUCTURE

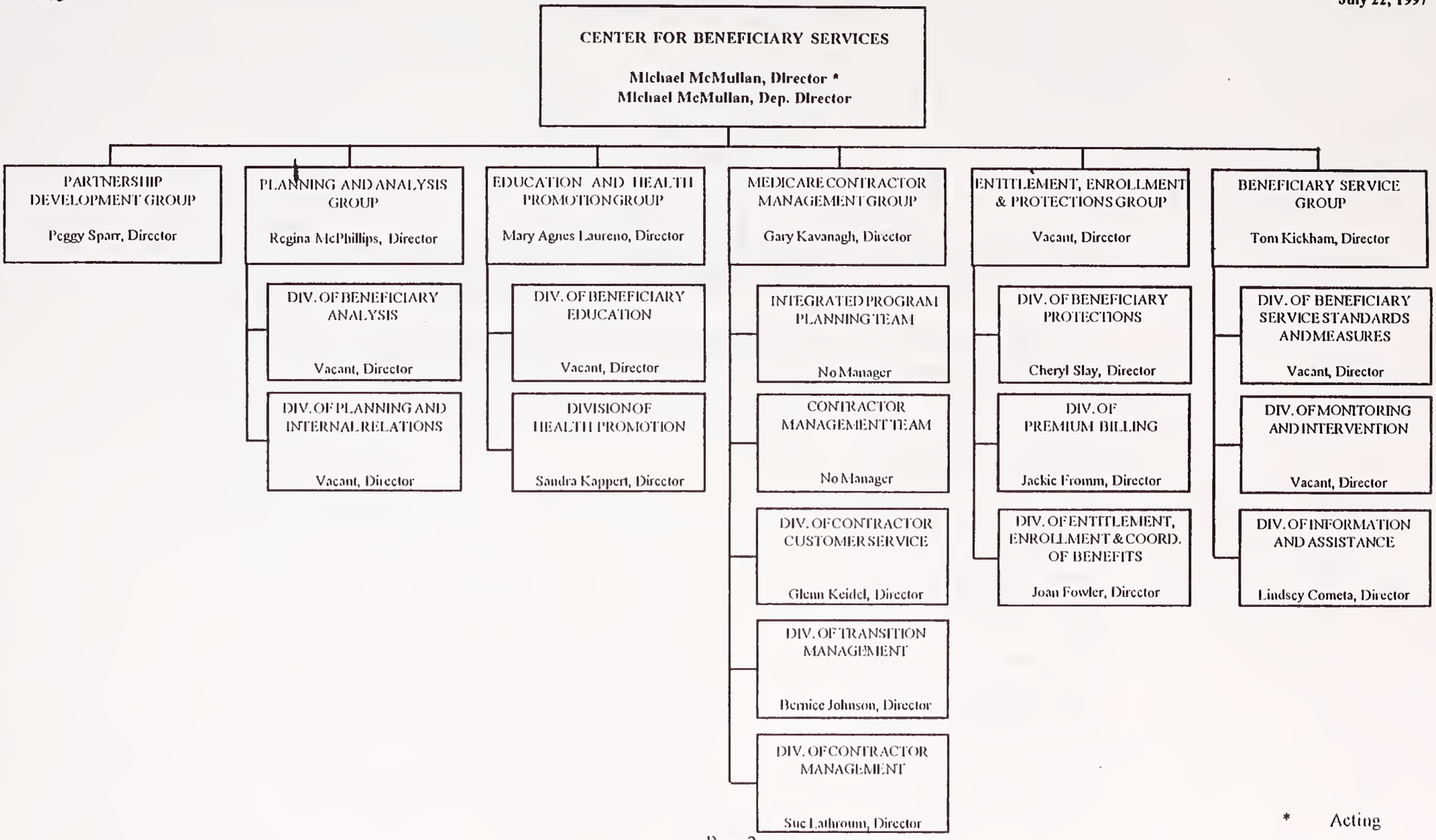
Date: 7/28/97



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of July 22, 1997

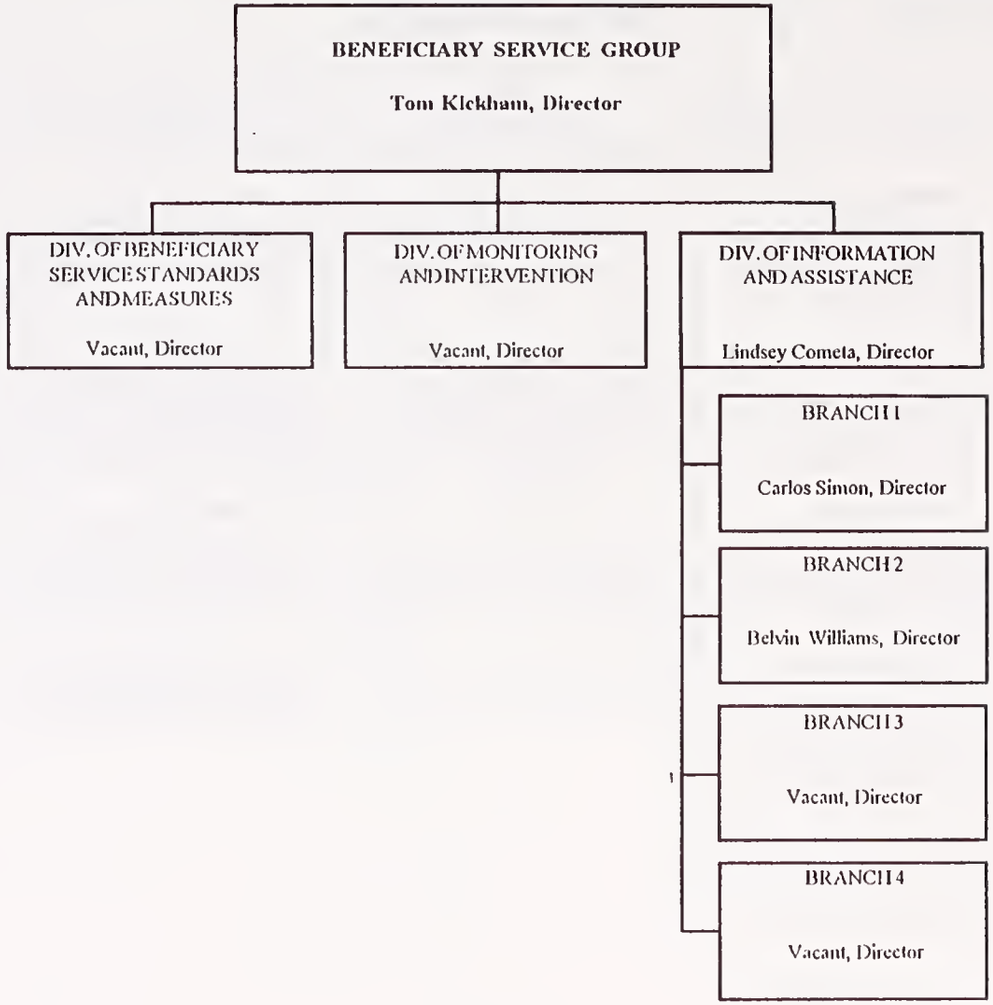


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CENTER FOR BENEFICIARY SERVICES

APPROVED
LEADERSHIP

As of
July 22, 1997

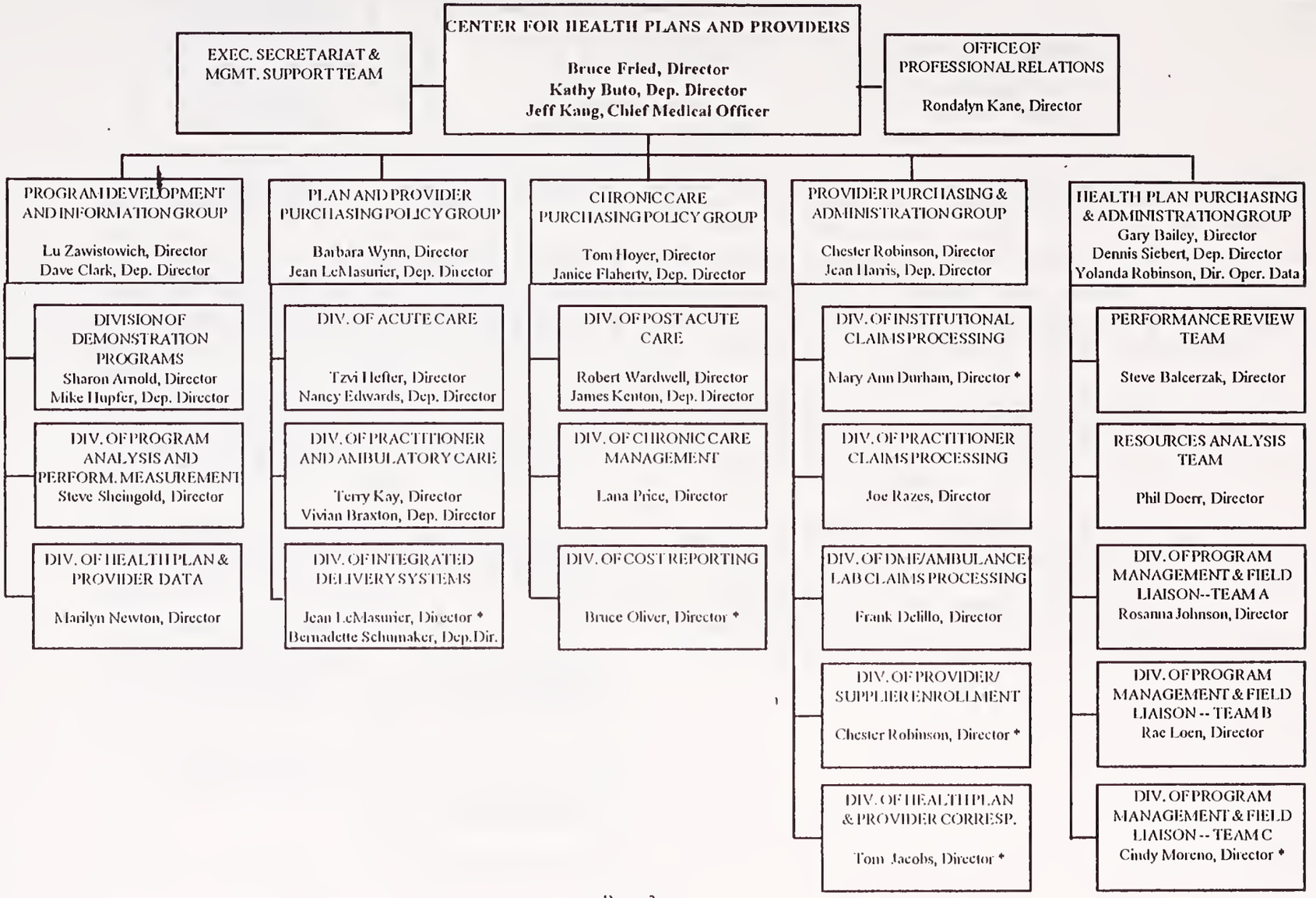


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of July 22, 1997



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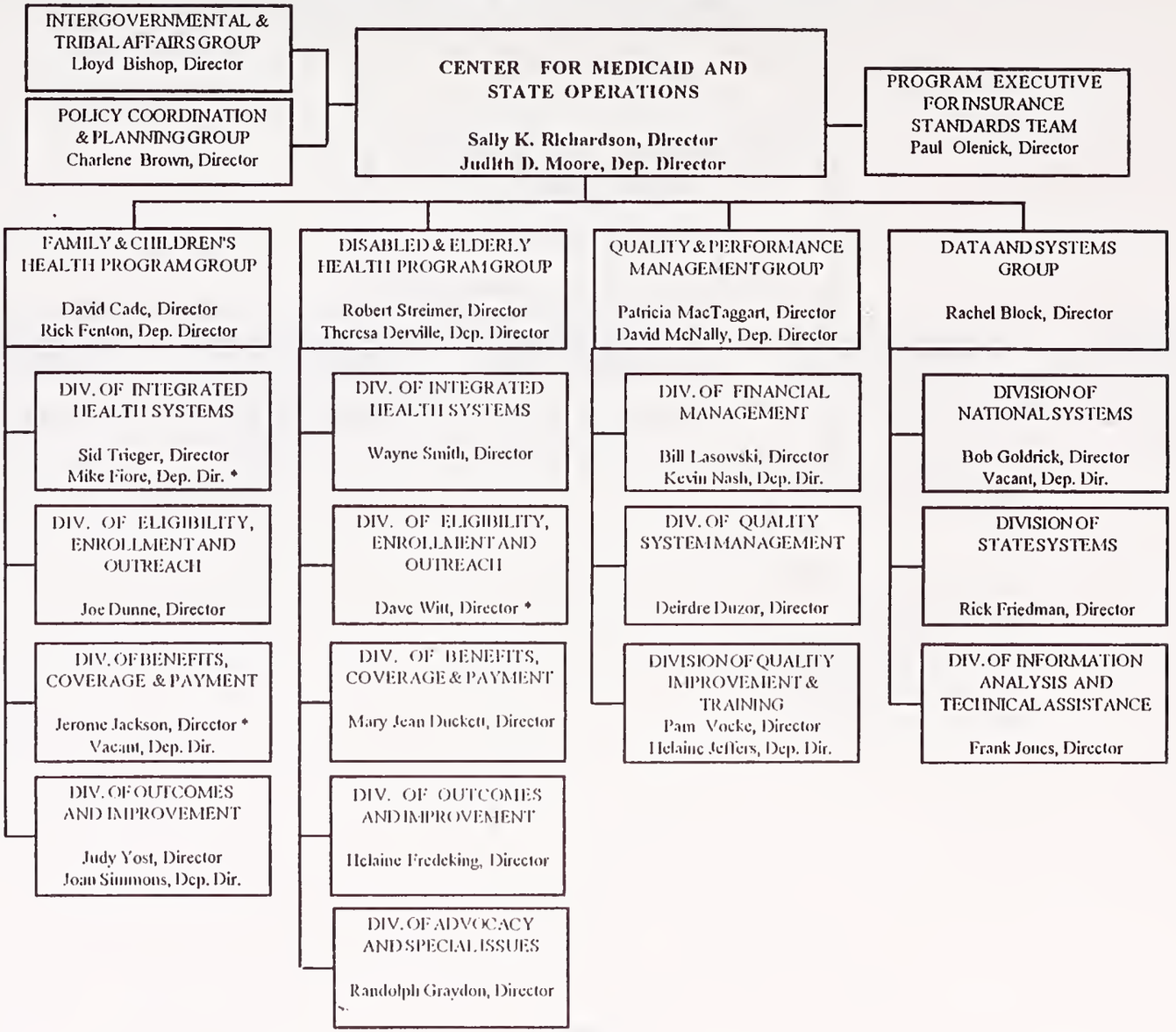
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of July 22, 1997

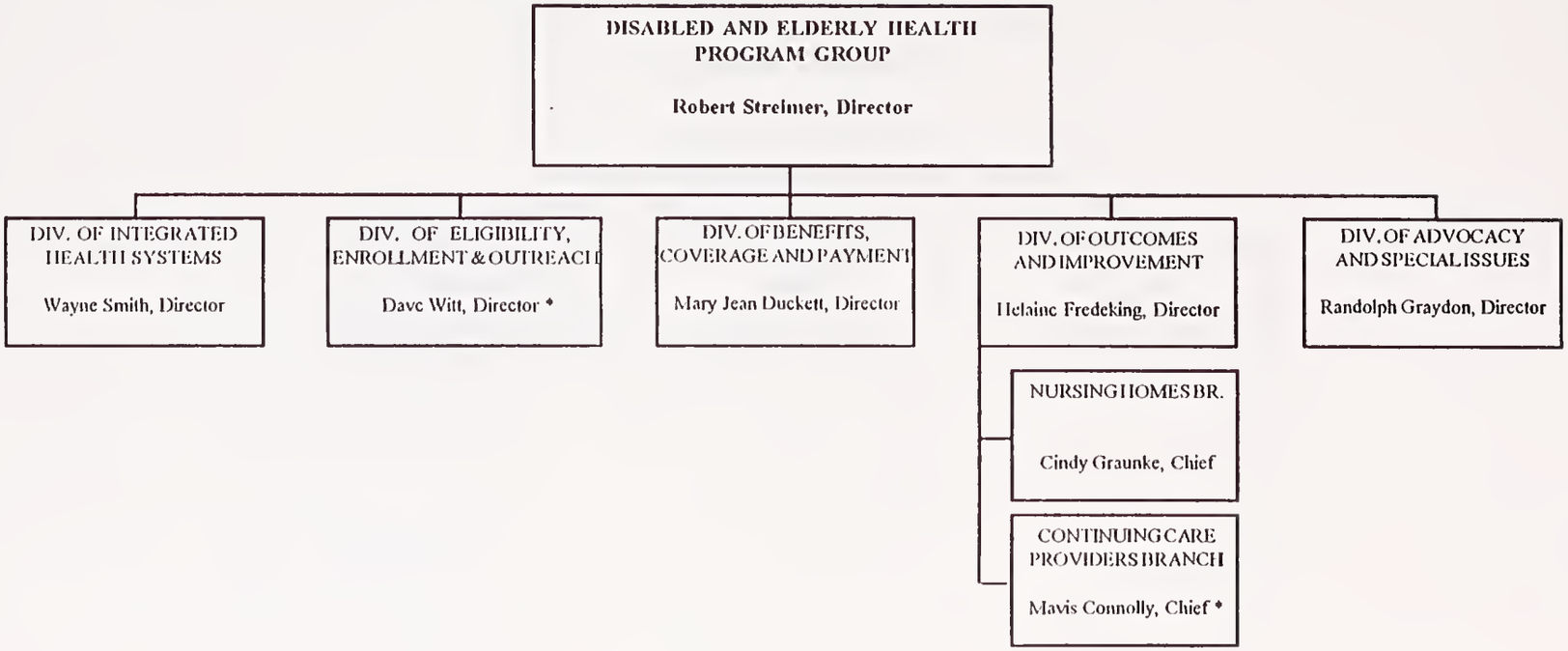


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CENTER FOR MEDICAID AND STATE OPERATIONS

APPROVED LEADERSHIP

As of July 22, 1997

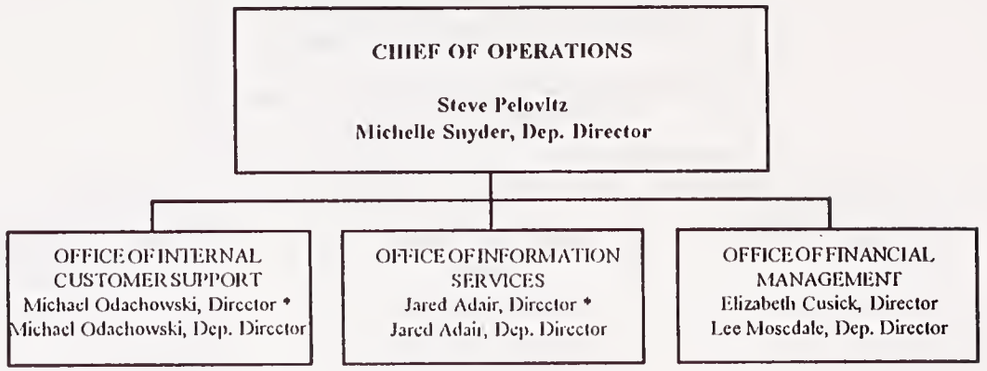


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of June 25, 1997

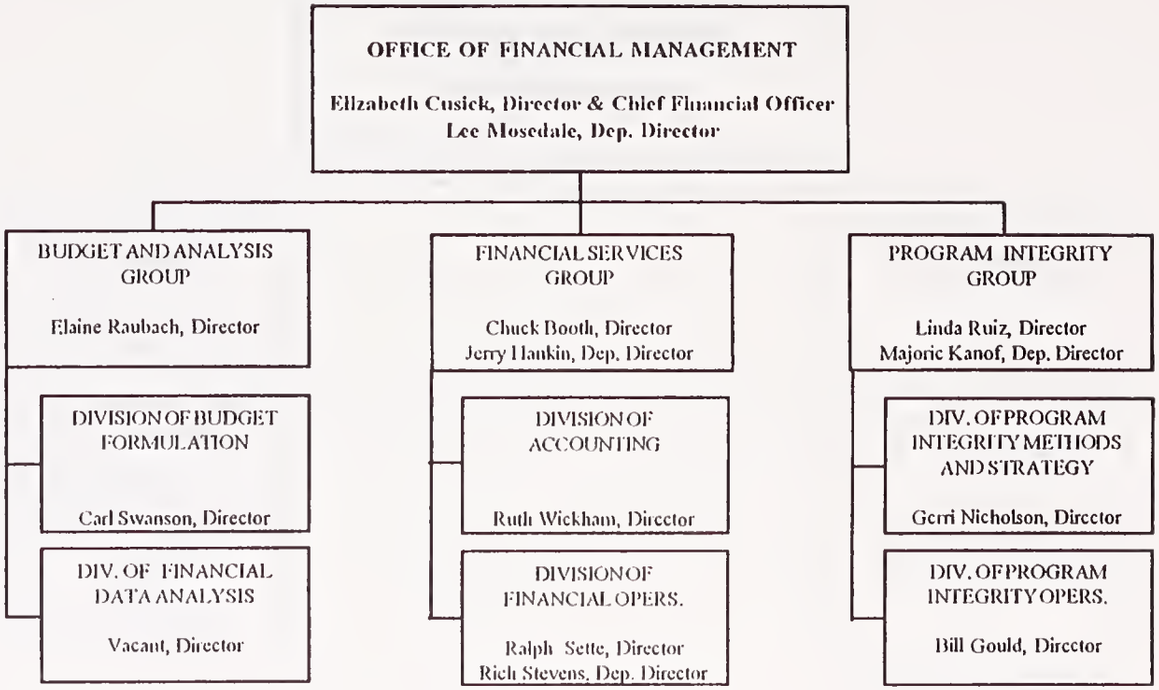


* Acting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS

APPROVED LEADERSHIP

As of June 25, 1997



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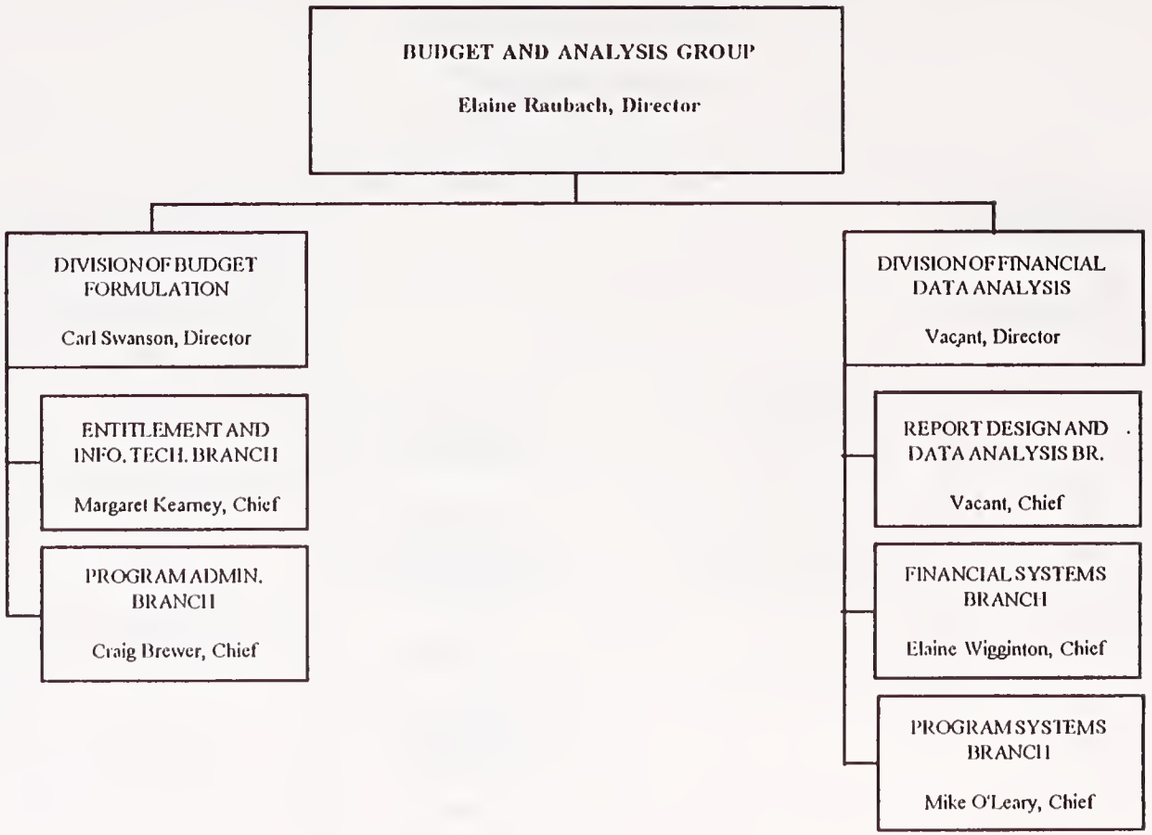
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS
OFFICE OF FINANCIAL MANAGEMENT

APPROVED LEADERSHIP

As of June 25, 1997



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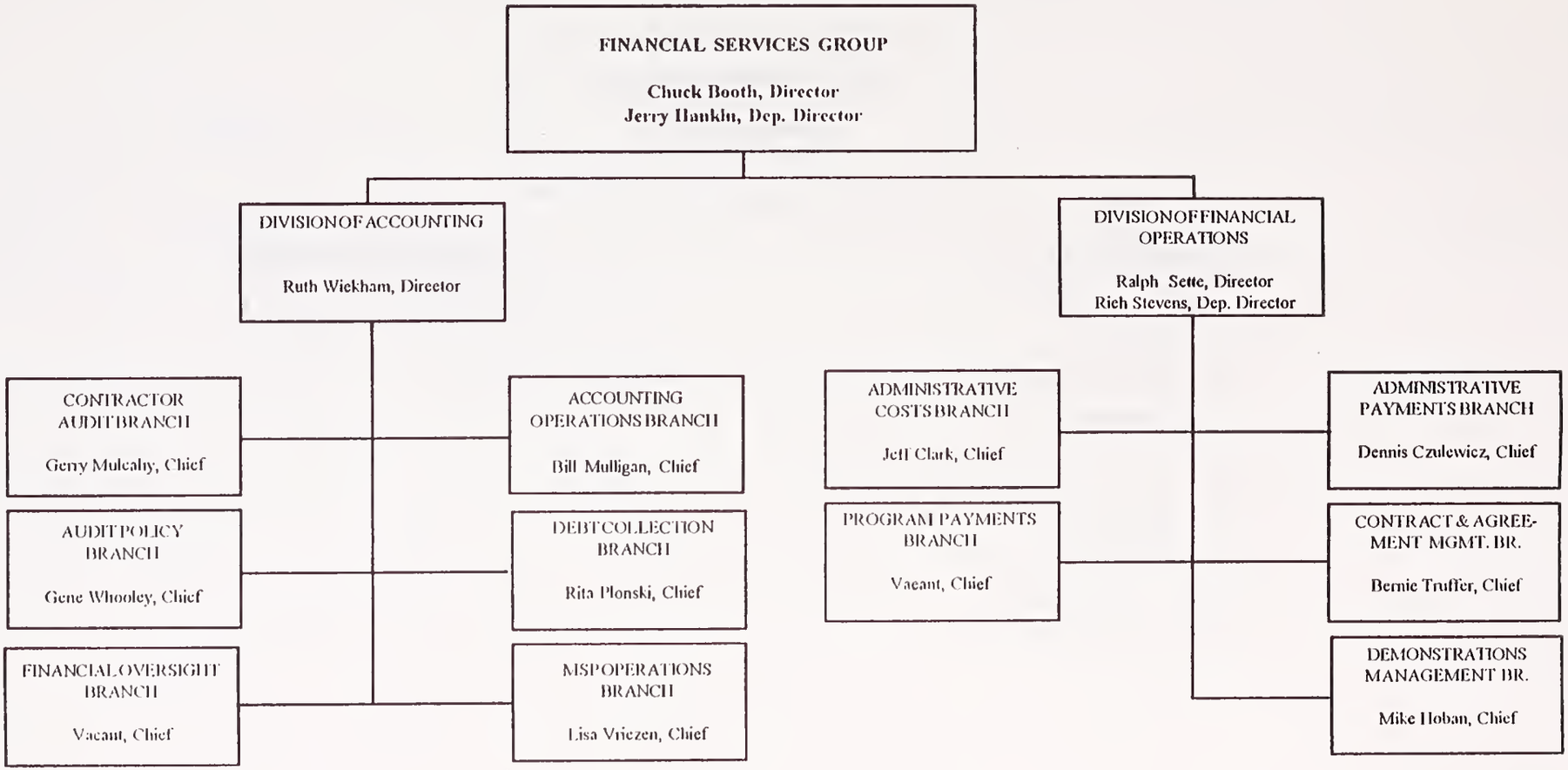
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS
OFFICE OF FINANCIAL MANAGEMENT

APPROVED LEADERSHIP

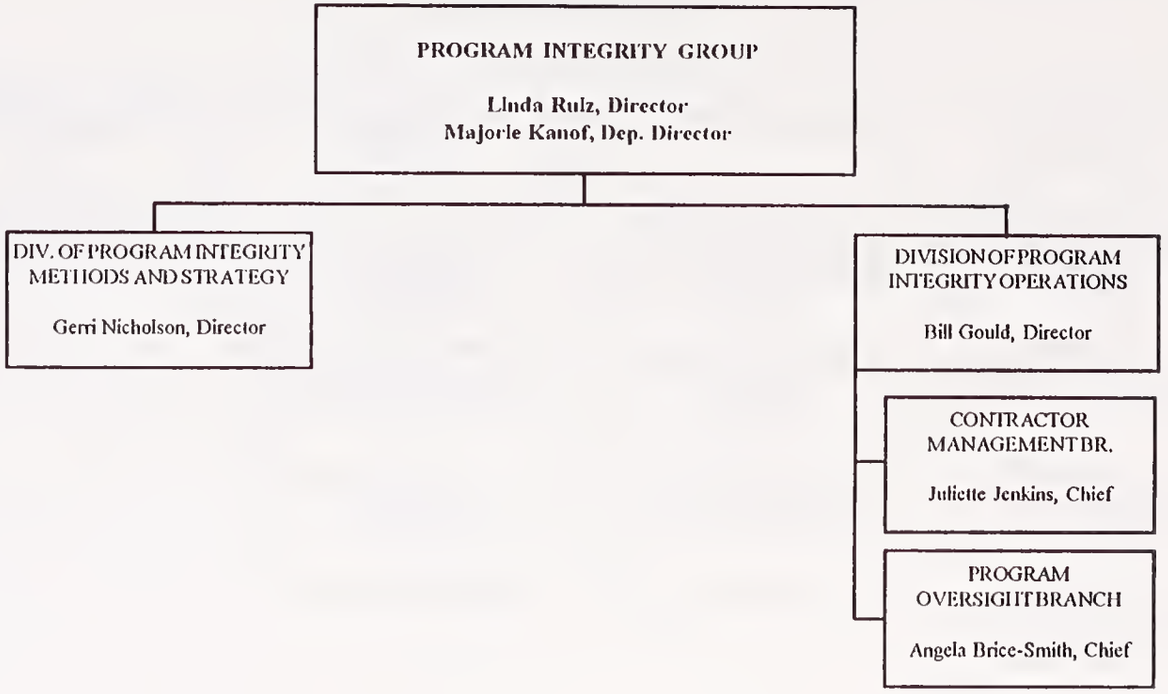
As of June 25, 1997



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS
OFFICE OF FINANCIAL MANAGEMENT

APPROVED
LEADERSHIP

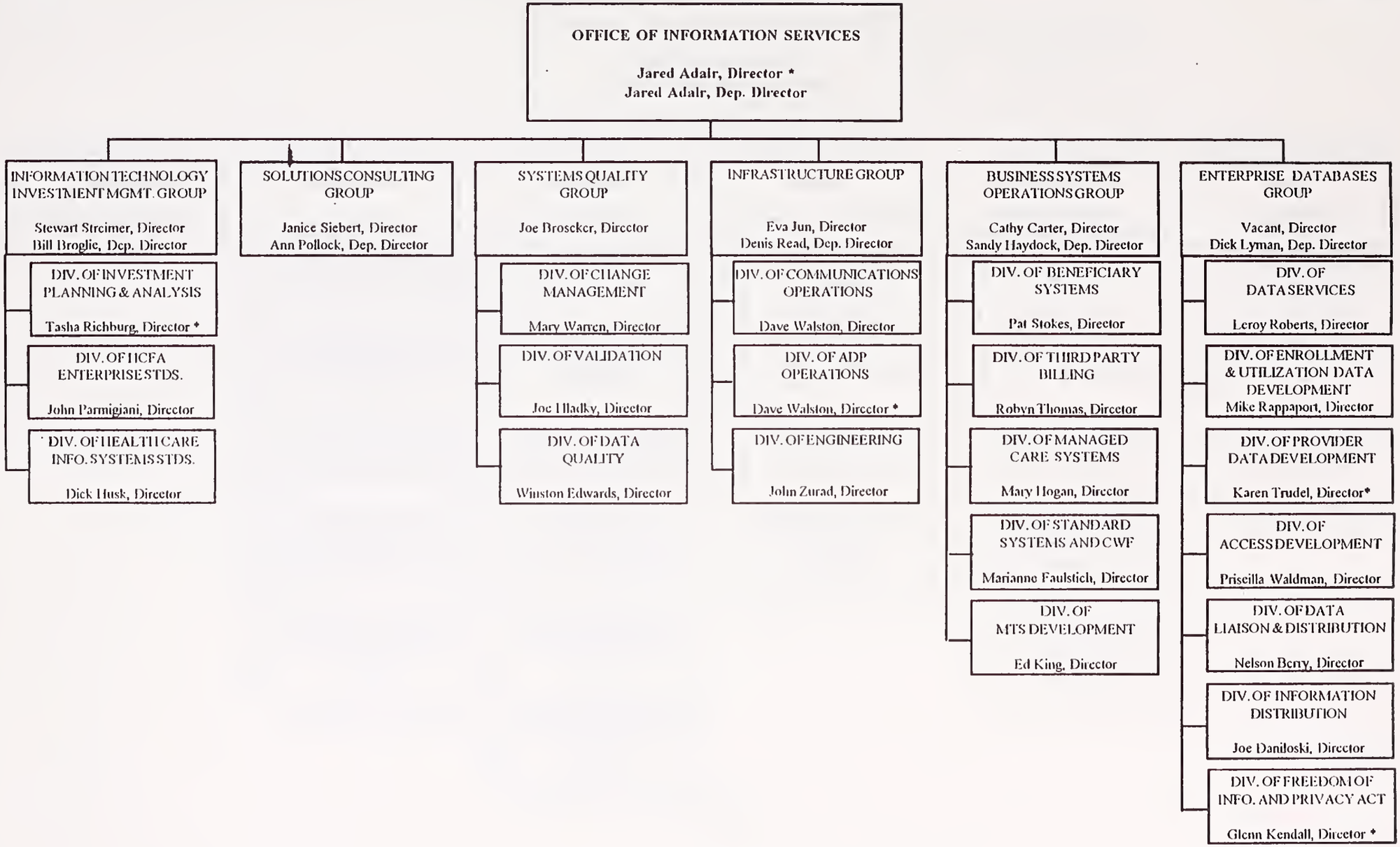
As of
June 25, 1997



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS

APPROVED LEADERSHIP

As of July 22, 1997



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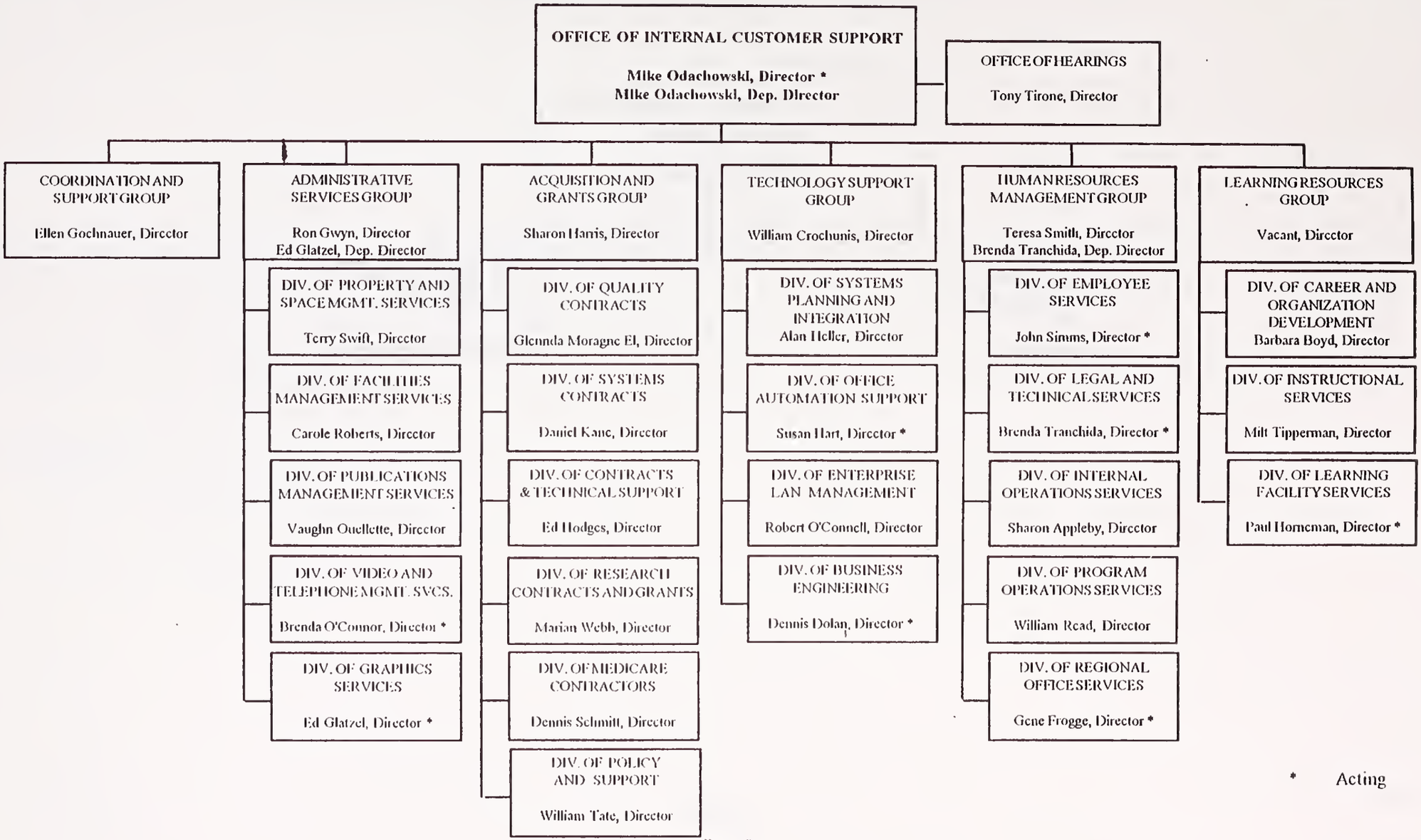
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS

APPROVED LEADERSHIP

As of July 22, 1997



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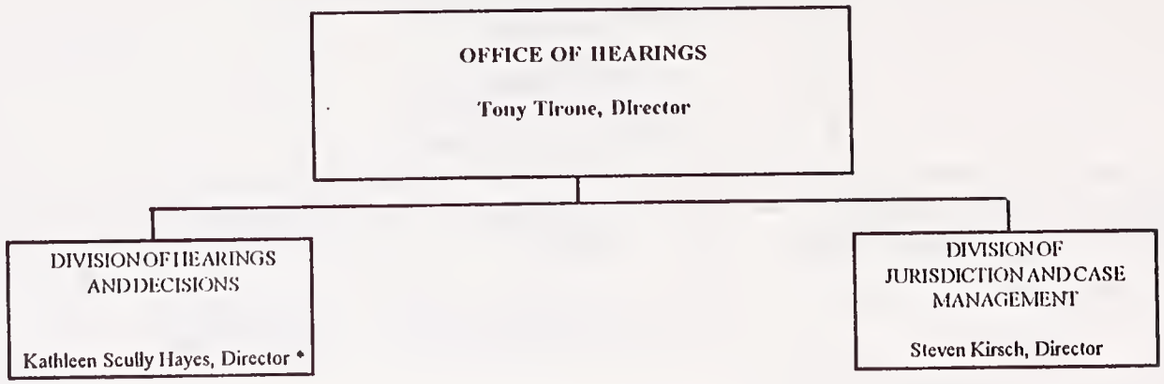
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
CHIEF OF OPERATIONS
OFFICE OF INTERNAL CUSTOMER SUPPORT

APPROVED LEADERSHIP

As of June 25, 1997



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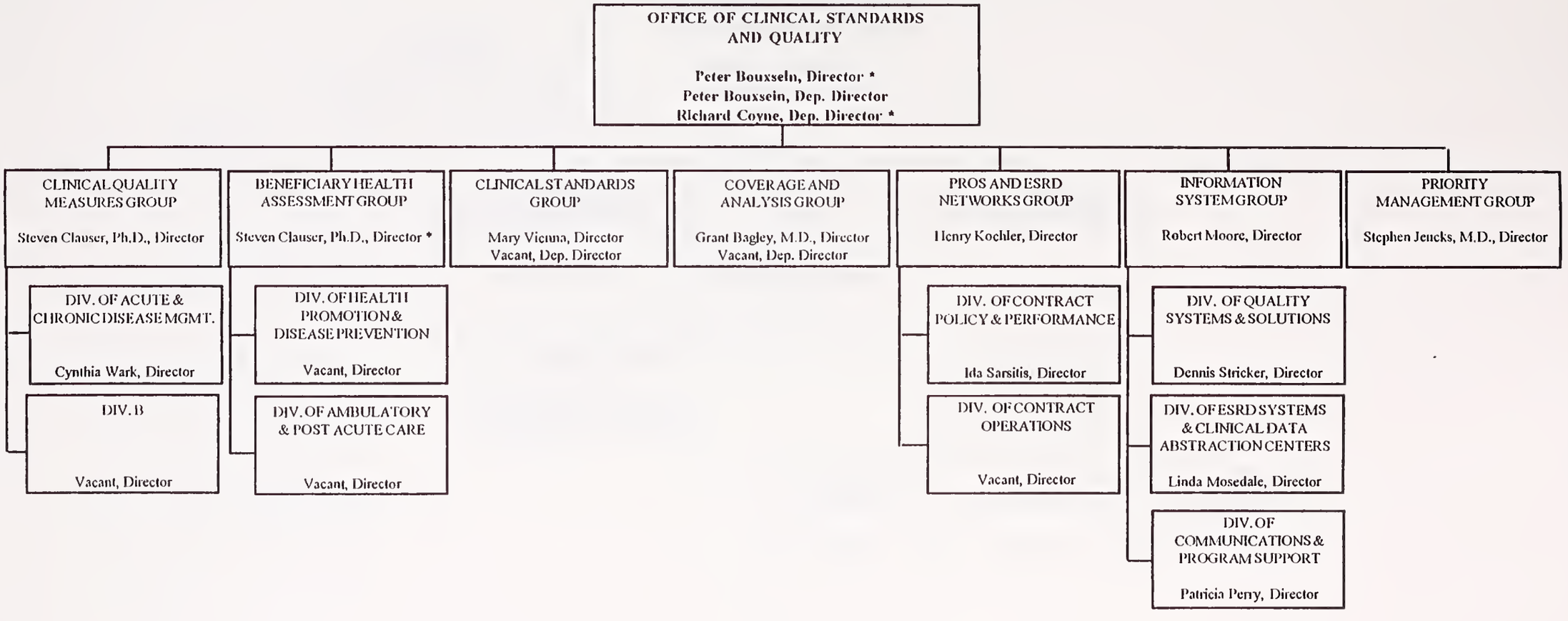
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of July 22, 1997



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HEALTH CARE FINANCING ADMINISTRATION

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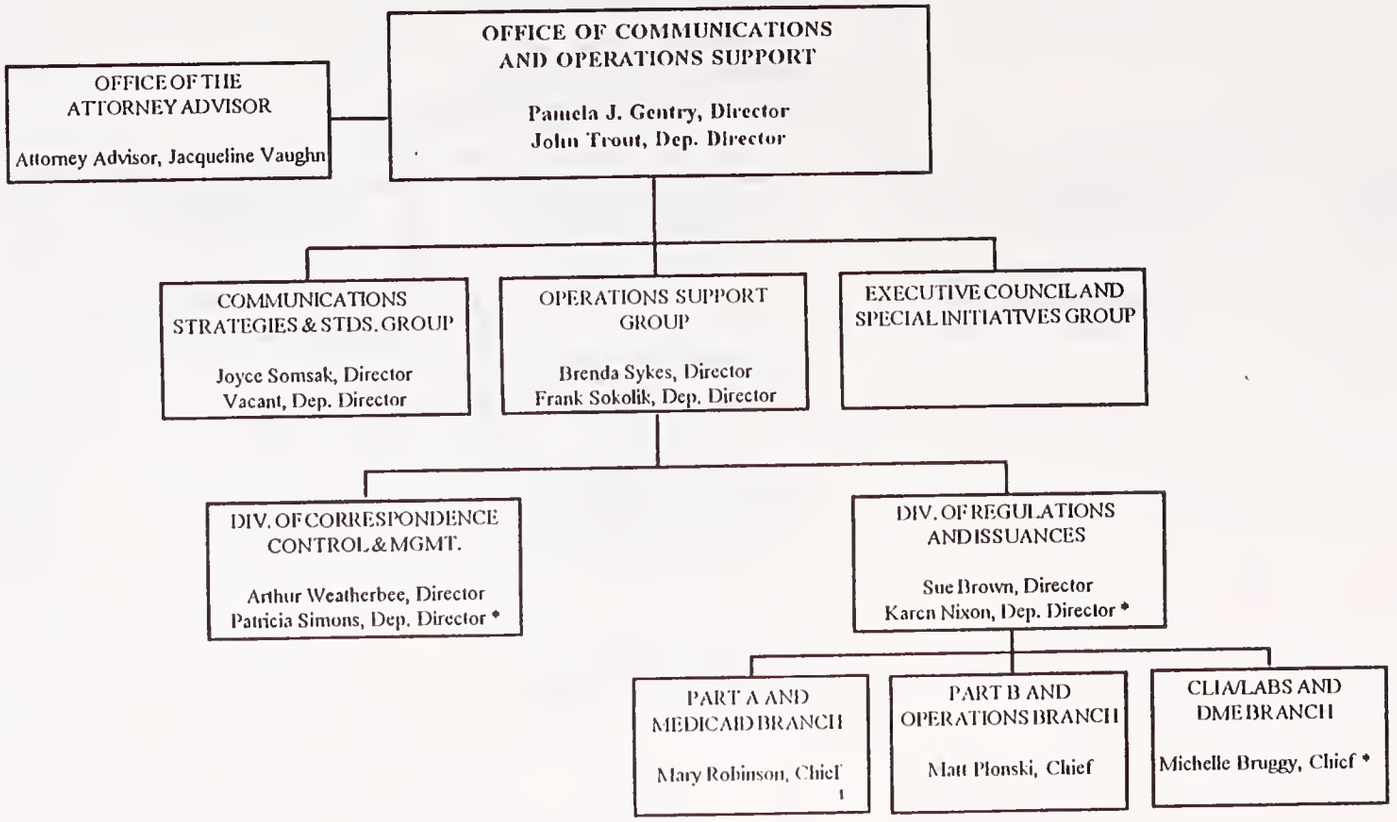
As of June 25, 1997



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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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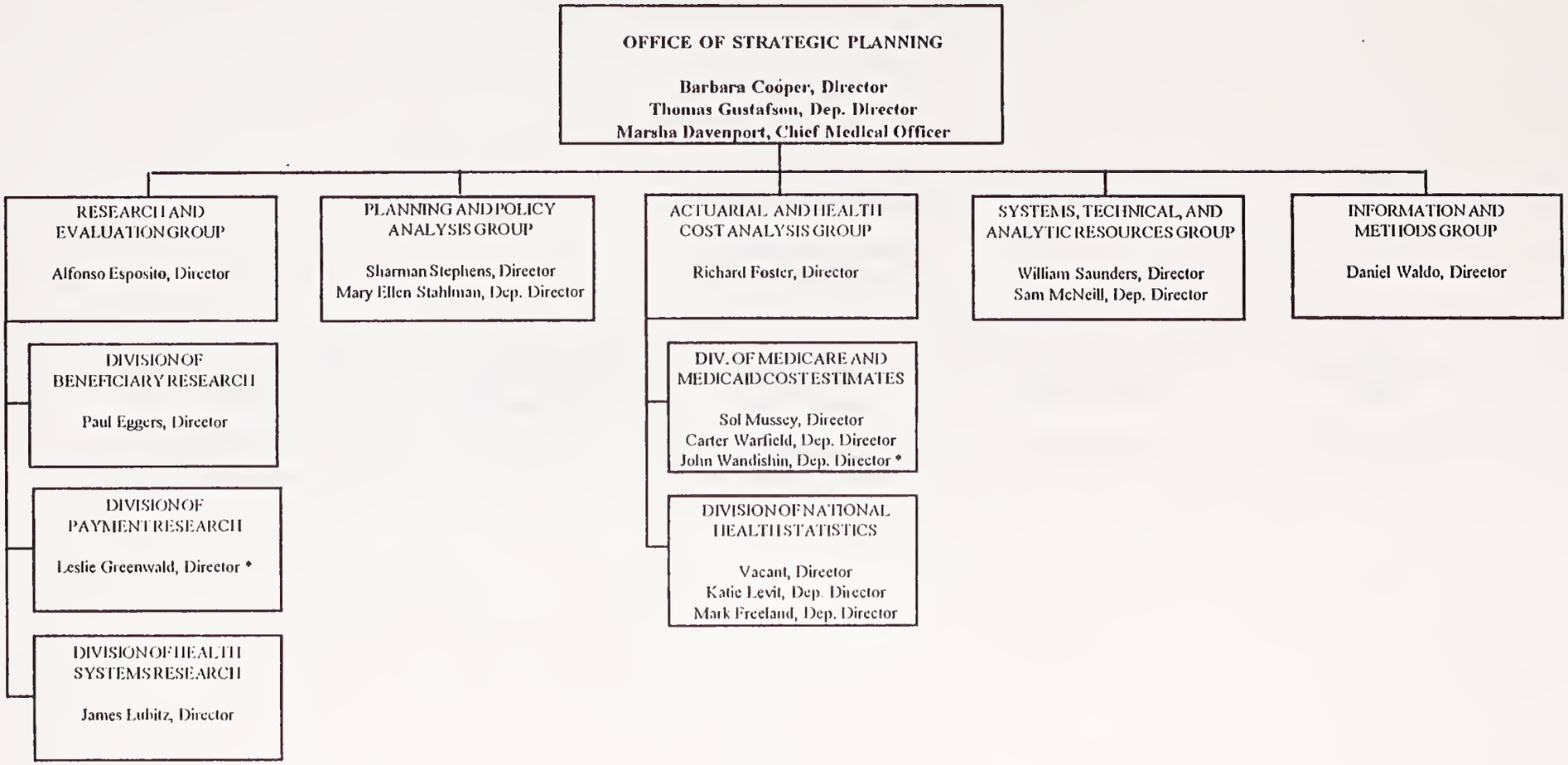
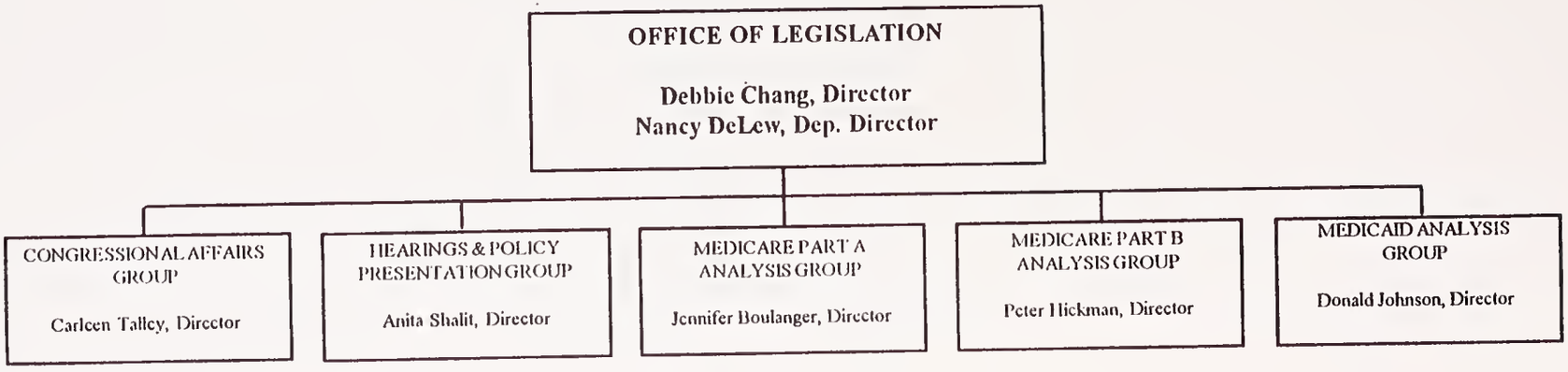
As of June 25, 1997



* Acting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CONGRESSIONAL AFFAIRS GROUP
Carleen Talley, Director
HEARINGS & POLICY PRESENTATION GROUP
Anita Shalit, Director
MEDICARE PART A ANALYSIS GROUP
Jennifer Boulanger, Director
MEDICARE PART B ANALYSIS GROUP
Peter Hickman, Director
MEDICAID ANALYSIS GROUP
Donald Johnson, Director

The

"HCFA Day"

Workgroup

Thank You

Planning, coordinating and executing a conference is a major undertaking which requires tremendous commitment and sacrifice. Special thanks to the members of the "HCFA Day" Work Group and other HCFA staff members who went "above and beyond" the normal course of business to make this year's conference a success.

Gary Bailey
Martha Dixon
Regina Fletcher
Darrell Gant
Shelia Gavin
Kirk Grothe
Robert Hardy
Bernice Harper
Rondalyn S. Kane
Jeff Kang
Ann Knievel
John Lanigan
Jean LeMasurier
Raemalee Loen
Jay Merchant
Steve Miller
Laura Minassian
Cynthia Moreno
Ann Moses
Dorothea Musgrave
Elias Papoulias
Mildred Reed
Sheri Smith
Donald Smith
Chapin Wilson

Notes

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