E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

07-Dec-1995 11:25am

TO: Carol H. Rasco

FROM: Diana M. Fortuna
Domestic Policy Council

CC: Julie E. Demeo
CC: Jennifer L. Klein

SUBJECT: Arkansas risk contract

HCFA tells me that they plan to act on Ark. BC/BS's request for a risk contract in about 3 weeks. The reason this has taken a while is that the application was incomplete.

I stressed yet again to HCFA that my call was merely to determine the status and that we are not asking them to do anything.

Apparently the reporter is also calling HCFA with questions; they will let me know more about this if there is anything interesting there.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

06-Dec-1995 03:05pm

TO: Julie E. Demeo

FROM: Carol H. Rasco
Domestic Policy Council

SUBJECT: RE: PH: Johnathan Wyle #501-399-3654

FYI, this is same guy from last week whom I do not intend to answer. However, I had forwarded his request last week to Jen, Chris and Diana telling them I did not intend to answer him but that I would like to know the status of the issue. Can you follow up with one of them? I haven't ;heard anything from them (which is understandabel given the budget shit going on!).

Thanks.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

04-Dec-1995 09:12am

TO: Christopher C. Jennings
TO: Diana M. Fortuna

FROM: Carol H. Rasco
Domestic Policy Council

CC: Julie E. Demeo

SUBJECT: See attached re: press call; Ark. Blue Cross / Blue Shield

I do not plan to return attached call and if the person calls again Julie and/or others will just continue to take messages for the time being.

Out of curiosity, do we know the current status of that request? I as always want to be careful any inquiries we make of HHS as simply to get info, nothing to indicate we are asking them to do anything.

Many thanks!

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

01-Dec-1995 05:25pm

TO: Carol H. Rasco

FROM: Julie E. Demeo
Domestic Policy Council

SUBJECT: Press Call

Damien took a call from John Weil of the Arkansas Democratic Gazette.

He called to inquire about your involvement with Arkansas Blue Cross/Blue Shield. Supposedely their is an issue regarding Medicare & HMO's that the DPC is dealing with and that he wanted your insight on.

His numbers are: office: (501) 399-3654
home: (501) 228-9232

Arkansas
BlueCross BlueShield

Robert D. Cahe
Executive Vice President,
Legal, Governmental Relations and
Communication Services
601 Gaines St.
P.O. Box 1489
Little Rock, Arkansas 72203-1489
(501) 378-2456
FAX (501) 378-2057

September 28, 1995

By Facsimile

Ms. Carol Rasco
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20005

Dear Carol:

I am writing to give you some more background regarding our meeting scheduled for 10:15 a.m. on Tuesday, October 3 in your office.

Arkansas Blue Cross and Blue Shield, through its wholly owned subsidiary, USAble Corporation, is a 50% owner of HMO Partners, Inc. The other 50% is owned by Baptist Health HMO, Inc., which, in turn, is owned by Baptist Health and approximately 270 physicians. HMO Partners, Inc. is the result of a merger of Health Advantage, the HMO formerly owned by Baptist Medical Systems HMO, Inc., and HMO Arkansas, Inc., which was formerly wholly owned by USAble Corporation.

HMO Partners, Inc. has a federally qualified line of business, which operates under the name of HMO Arkansas. HMO Partners, Inc. has two applications presently pending at the Health Care Financing Administration:

1. The first application is for approval as a Medicare risk contractor. That application has been pending for several weeks, and a site visit was held in early September.

2. The second application is for an expansion of the service area for the federally qualified line of business. That service area presently encompasses four counties in Central Arkansas and two counties in Western Arkansas. The approval sought would be for an expansion to a virtually state-wide operation.

Another topic which we would like to discuss is the proposition, found in at least two measures pending before Congress, that physicians and hospitals should be able to organize and offer HMO-like products without complying with the licensing requirements that HMOs typically are required to meet. We believe that this has the potential to expose Arkansans to very troublesome consequences.

As you may know, Arkansas Blue Cross and Blue Shield is a corporate sponsor of the event for Arkansans scheduled for Friday evening. Sharon Allen and I will be in attendance and hope to see you there.

With best regards, I am

Cordially yours,

Bob

Robert D. Cabe

RDC:baj

Arkansas
BlueCross BlueShield

Robert D. Cabe
Executive Vice President,
Legal, Governmental Relations and
Communication Services
601 Gaines St.
P.O. Box 1489
Little Rock, Arkansas 72203-1489
(501) 378-2436
FAX (501) 378-2037

547-4520

4-6 wks.
2 wks to decision

May 15, 1995

MAY 16 1995

Ms. Carol Rasco
The White House
1600 Pennsylvania Avenue N.W.
Washington, D.C. 20500

By Telefax

OMC staff awaiting write up from region, w/in 1-2 wks

Dear Carol:

Thanks very much for making time on your schedule for Sharon Allen and I to visit with you this Thursday, May 18, at 11:15 a.m. We assume that we should enter the northwest gate; if this is incorrect, please have someone give us the appropriate information.

9/5 Completed went well

We hope to visit with you about the following subjects:

August site visit — hope it doesn't slip

1. Medicare Risk Contract. As we discussed in December, our federally qualified HMO subsidiary is actively pursuing a Medicare risk contract. An application has been filed and we are working toward a January 1, 1996 effective date. We would like to give you a short update on the status of that project.

   Senate / hesitant to enter / aware of lack of data — 18 mos — 3-5 better

2. Medicare Select. We are very interested in the possibility of being able to offer a Medicare select-type product in Arkansas, and would like to share our views on this.

   good for transition in Ak from FFS to m.c.

3. Medicare Budget Cuts. While we would probably be preaching to the choir, we would like to give you our views from the perspective of a Medicare contractor with nearly thirty years' experience in the program.

   operating % — <2% for MC — expand efficiency; payment safeguards; ALJ's particularly — need education

4. Any Willing Provider. As you may know, Arkansas will have, as of July 27, 1995, a very broad and comprehensive any willing provider statute. As written, it would purport to apply to health maintenance organizations, without distinction between state certified HMOs and federally qualified HMOs. In our view, the Arkansas statute is inconsistent with the federal HMO statute, which provides for a pre-emption of state laws which prevent health maintenance organizations from operating as federally qualified HMOs. It is our understanding that HCFA has not rendered an opinion with respect to pre-emption of an any willing provider statute. In the interest of promoting cost-effective and high quality managed care, it would seem to us appropriate that HCFA take a lead role on this issue, and we would like to discuss that with you.

Ark broadest — hasn't reg'd table → Bruce; didn't want adverse; Wash law firm advice from HCFA
HCFA opinion would help on Court
If a priority of Admin. ..
Timing — CR

(where is AMA?)

If there is any information we might provide you in advance of our discussions on Thursday, please let me know and we will of course be happy to provide it.

With best regards, I am

Cordially yours,

Bob

Robert D. Cabe

RDC:baj
cc: Mrs. Sharon Allen

10/3/95

Filed by HMO other than Baptist – HMO Partners Inc – renamed

expand fed'ly q service area

HMO Ark – was fed'ly qualified, as was Baptist

now 9 counties

Applic 2–3 mos ago – on-site review

Assumes on-site rev not needed for Comm'l

Seemed to mgt'y went well

13 weeks from then – told @ last interview

(others in pipeline first)

a number of follow-up conversations – Pos – Comm'l – MC

Update in hands tomorrow

Esp int'd in MC side

PHO exemptions bad idea – benes @ risk

AWP – sued in June providers who demanded entry

Then sued state officials

Both transferred to Jim Moody's court

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

18-May-1995 10:50am

TO: Carol H. Rasco

FROM: Diana M. Fortuna
Domestic Policy Council

CC: Jeremy D. Benami

SUBJECT: Meeting with Bob Cabe

Although we are planning to just listen at the meeting with Bob Cabe, here are the points he wants to raise along with some background information on each one:

1. His federally qualified HMO has an application pending at HCFA to provide managed care services for Medicare beneficiaries via a Medicare risk contract. He wants to update you on the status of the application, and his letter doesn't sound like he has any complaints.

HCFA requested additional information on May 1 and they will make a decision within 60 days after they receive the additional information. They see no major problem with the application.

2. Cabe says he is interested in being able to offer a Medicare Select-type product in Arkansas, and "would like to share our views on this."

By law, the Medicare Select demonstration can only operate in 15 states, and Arkansas is not one of the 15. Legislation to extend the demonstration to all 50 states was passed by the House and just yesterday in the Senate. The administration had taken the position that there are enough questions about quality of care, consumer protections, and the program's value that it should not be extended to all 50 states, but Chris J. told me today that, with the action in the Senate, we are not going to oppose to 50-state model, but simply make sure that the program is monitored closely.

So I think we can say to Cabe that it looks like Congress will extend the program to all 50 states, and that we will be working to make sure that it is a high quality program.

(Medicare Select is a weird program that is less than a full-blown ppo, but provides some sort of Medigap wraparound. I am trying to get a better description but I have always found this one somewhat baffling.)

3. Cabe wants to talk about Medicare budget cuts, which he agreed will be "preaching to the choir."

4. Cabe says that a law will go into effect in Arkansas in July mandating that "any willing provider" can provide services to beneficiaries enrolled in managed care. (Managed care organizations hate these laws because it reduces their ability to select providers and manage costs. Providers like them because they don't want to be locked out of managed care plans.)

Cabe says that the law purports to apply to federally qualified HMOs like his own, but he thinks that the federal HMO statute preempts such state laws. He says that HCFA has not rendered an opinion on this, and that he thinks they should.

According to HCFA, they have agreed with Cabe's point in 2 states that have any willing provider laws (Maryland and Virginia). They have written letters saying so, and the letters have received some coverage in the trade press. They would say the same thing about the Arkansas law. (None of this has been tested in court yet, though.)

We can tell Cabe that HCFA has been active on this issue in 2 states, and give him copies of the 2 letters.

Managed Care Issues

1. Medicare Risk Contract

   On May 1, HCFA's Office of Managed Care sent HMO Arkansas (AR BC/BS's HMO) a letter requesting additional information because their Medicare risk contract application was incomplete. Once the additional information is received, a decision on the application will follow within 60 days. [Note: Aside from needing additional information, thus far, no major problems with their application have arisen.]

2. Medicare SELECT

   Arkansas is not one of the 15 designated states in the Medicare SELECT demonstration. Therefore, AR BC/BS cannot participate in the program as it currently operates. The Senate passed legislation today, already passed by the House, extending the SELECT program and expanding it to all 50 states. If signed by the President, AR BC/BS could conceivably participate; the Administration however, has expressed opposition to the SELECT extension/expansion due to inadequate consumer protections and quality of care safeguards. Further, the evaluation of the SELECT demonstration will not be complete until this fall, giving us little idea at this point of the program's value. We support a 12-month extension of the 15-state demonstration in order to review the evaluation. Our preference is to replace SELECT with a Medicare "Preferred Provider Option" (PPO). [HCFA's legislative proposal for the PPO is currently pending at OMB.]

   - AR BC/BS may well like the PPO option if they are interested in SELECT (fewer restrictions than the Medicare risk program). PPOs were the insurance industry's response to the rise of HMO and the Blues are heavily into the PPO market.

3. Medicare Budget Cuts

   Medicare budget cuts of the size being discussed in Congress would have significant impact on the Medicare managed care program. Increases in beneficiary copayments and deductibles and reductions in payments to providers would place downward pressure on the AAPCC (which is calculated on historical fee-for-service claims data), resulting in much lower payments to Medicare risk contractors. This will likely result in zero- or low-premium Medicare plans (over 50% of Medicare contractors offer zero-premium products) being forced to increase their premiums and/or cut supplemental benefits, such as prescription drugs or eyeglasses -- the principal incentives for Medicare beneficiaries to enroll in managed care plans. The effect would be the opposite of Congress' intent: fewer Medicare beneficiaries joining HMOs, and more leaving them.

4. Any Willing Provider

   By Federal law, Federally Qualified HMOs are protected from restrictive state laws; further,

hasn't been tested in court

Medicare managed care regulations specifically protect the right of contracting health plans to determine the type of practitioner that will provide covered services to enrolled beneficiaries. HCFA, commenting on laws passed by Maryland and Virginia similar to the one about to be enacted in Arkansas, stated that these provisions pre-empted state "any willing provider" laws. [copies of the letters and a press report of the letters are attached]

Any Willing Provider Laws

HCFA: Va. ancillary provider law makes HMOs too much like FFS plans

A potentially new strain of any willing provider law may have been snuffed out by the Health Care Financing Administration. The agency has ruled that federally qualified HMOs in Virginia are not allowed to comply with a state law HCFA says would strip them of the ability to manage care by forcing them to cover unrestricted ancillary services.

The situation was brought to HCFA's attention by the Kaiser Foundation Health Plan. In a letter to Rodney C. Armstead, director of HCFA's Office of Managed Care, Judith M. Mears, Kaiser's vice president and assistant general counsel, cited a 1988 amendment to the HMO Act that allowed FQHMO members to receive no more than 10% of non-emergency services from providers not affiliated with the HMO.

"The amendment reflects Congress' concern that permitting more than 10% of an HMO's services to be obtained outside the plan would compromise a basic characteristic of federally qualified HMOs," Mears said. If they could not be solely responsible for the majority of an enrollee's care, FQHMOs could not conform to that part of the HMO Act that charges them with protecting enrollees when they receive medical services, she added. Further, the Virginia law "mandates an HMO to adopt indemnity-like characteristics in violation of the HMO Act and the essential character of prepaid FQHMOs."

In his response to Mears' letter, Armstead questioned whether HMOs that followed the law could even be considered HMOs. "While not in our jurisdiction, we also anticipate that the Internal Revenue Service may question the tax-exempt status of non-profit FQHMOs in Virginia because of the shift in the nature of the plan toward insurance," he added.

What's the next step? "That's the $64,000 question," says Sarah Hopkins Finley, an attorney with Williams, Mullen, Christian & Dobbins, Richmond. She says the state legislature is entertaining one bill to repeal the provision entirely and one to restrict qualified ancillary service providers to those who have previously notified the HMO of their agreement to accept patients at rates paid participating ancillary service providers.

Legislation to repeal the provision has passed the state House of Delegates and will be taken up by the Senate soon. The state's Joint Commission on Health Care has been assigned to study the issue over the next three years. Call Finley at (804)783-6481 for details.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Director's Office
Washington, D.C. 20201

DEC - 5 1994

Judith M. Mears
Vice President and Assistant
General Counsel
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, California 94612

Dear Ms. Mears:

We have reviewed your November 7, 1994, letter (and attachments) representing the concerns of Kaiser Foundation Health Plan of Mid-Atlantic States regarding recently enacted legislation by the Commonwealth of Virginia.

We believe that Federally qualified health maintenance organizations (FQHMOs) do not have to comply with the law at issue, Chap. 963 of the Acts of the General Assembly of Virginia, 1994 House Bill 840 (referred to as Chap. 963), with regard to payment for ancillary services because this law is in conflict with portions of Title XIII of the Public Health Service Act (the HMO Act) and implementing regulations at 42 CFR 417.

The HMO Act and regulatory provisions governing FQHMOs require participating health plans to provide or arrange for all basic health services, with the exception of medical emergencies. (See 42 U.S.C. 300e, 300e-1; 42 CFR 417.103) The HMO Amendments of 1988, P.L. 10-517, allows FQHMOs to offer a self-referral option for physician services, i.e., enrollees may seek care from non-plan physicians within guidelines established by the FQHMO. This statutory provision sets a 10 percent "cap" on out-of-plan physician services and does not permit out-of-plan ancillary services, at least not in the broad, undefined context of Chap. 963. As you know, the 1988 Amendments were considered self-implementing, but a notice of proposed rule making on the self referral option has been published and a final rule is under development. Compliance with Chap. 963 would require HMOs to permit practices that would violate the above Federal requirements.

We also believe that 42 U.S. C. 300e-10 is applicable in this situation. This provision of the HMO Act states:

> In the case of an entity--
>
> (1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise--

> . . . (E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, and
>
> (2) . . . which is a qualified health maintenance organization for purposes of section 300e-9 of this title,
>
> such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e-9 of this title.

The Virginia law in question would prevent an FQHMO from providing and arranging for basic health services as discussed previously. Further, in that the definition of an HMO involves the interrelationship of providing comprehensive benefits in-plan, risk sharing with providers, utilization management through plan-established practice guidelines, and quality assurance mechanisms (including grievance and appeal procedures), Chap. 963 has the effect of undermining the very nature of a prepaid health plan and shifting consideration of these entities toward that of an indemnity insurance product. HCFA will have to question whether FQHMOs complying with ancillary services provisions of Chap. 963 could be considered HMOs. While not in our jurisdiction, we also anticipate that the Internal Revenue Service may question the tax-exempt status of non-profit FQHMOs in Virginia because of the shift in the nature of the plan toward insurance.

While there are a number of policy concerns about the Virginia law--such as the implementation and impact of Chap. 963 under capitated payment arrangements, the impact on fiscal soundness and insolvency protection, and the weakening of continuity and care management--we are limiting this letter to the serious legal concerns involved with this state legislation.

Sincerely,

Rodney C. Armstead, M.D.
Director

cc:
Bruce Vladeck

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Director's Office
Washington, D.C. 20201

MAY 11 1995

Charles W. Stellar
President
American Managed Care and Review Association
1227 25th Street, NW, Suite 610
Washington, D.C. 20037-1156

Dear Mr. Stellar:

Your organization is concerned about the impact on health maintenance organizations (HMOs) of certain legislation under consideration in the state of Maryland. In particular, you are concerned about the impact that the Patient Access Act now before the Governor, may have on federally qualified HMOs (FQHMOs). We have reviewed the enrolled bill and have the following comments.

FQHMO Compliance with the HMO Act

Section 19-710.2 of the Patient Access Act (as enrolled) requires HMOs to make a point-of-service (POS) option available to employees and individuals who have no other option of receiving health benefits through their employer, association or private group. We believe this provision could be in conflict with the Title XIII of the Public Health Service Act (the HMO Act), specifically the self-referral option enacted by Congress in the HMO Amendments of 1988 (P.L. 100-517). Under the HMO Act, FQHMOs may offer a "self-referral option" for physician services, i.e. enrollees may seek care from non-plan physicians within guidelines established by the FQHMO. This statutory provision sets a 10 percent "cap" on out-of-plan physician services. Other services, such as hospital care, can be obtained out-of-plan only if permitted and preauthorized by the FQHMO. As you know, the 1988 Amendments were considered self-implementing, but a notice of proposed rulemaking on the self-referral option has been published and a final rule is under development.

Although there is a provision in the Maryland legislation that limits the applicability of the POS requirement to FQHMOs to the extent permitted under federal law, the mandate could put a FQHMO in jeopardy of exceeding the 10 percent limit. The enrolled bill does not specifically provide FQHMOs with a waiver to cease offering the POS option to eligible employees if it reaches the 10 percent "cap." The bill also does not address whether these employers, associations, and private groups would take precedent over the FQHMO's other commercial, Medicaid, and Medicare enrollments in having the POS product available. The Office of Managed Care anticipates monitoring the 10 percent limit across all product lines of a FQHMO, not on a contract by contract basis.

Federal Preemption Authority

Section 1311 of the HMO Act (42 U.S.C. 300e-10) provides FQHMOs with protection from restrictive state laws. While the requirements of the Patient Access Act do not appear to invoke any provisions of this section, we cannot comment conclusively at this time. In developing regulations, State officials will make policy interpretations, and it is possible that some of the regulatory requirements may be in conflict with Section 1311.

Below, we take the opportunity to provide additional comments on the Maryland Patient Access Act.

Creation of an "Unlevel Playing Field"

The Patient Access sets forth certain accountability requirements and higher performance standards, but only on one segment of the managed care industry. It appears to us that any health care system which establishes a panel of providers and which sets financial incentives for members to obtain services from that panel, including preferred provider organizations, exclusive provider organizations, and integrated delivery systems, should be required along with HMOs to:

- meet the application and processing requirements for provider applicants as set forth in the bill and be subject to penalties for failure to comply,
- make efforts to include minority providers,
- not deny participation on the basis of gender, race, age, religion, national origin, or certain disabilities, or based on the provider's grievance history,
- have an internal review system to hear disputes of providers being terminated from the plan panel,
- provide a current list of providers and information as to which participating providers are "full" (not accepting new members) and to existing members at least once a year,
- provide clear information to members as to how to file a complaint about the plan with State officials,
- keep panel members informed of terminations (as well as which members of specialty practices are participating), and
- notify members in advance when providers are being terminated from the panel.

In addition, any managed health care plan that applies utilization review and management techniques should have internal

review systems to hear provider grievances and allow providers to advocate in the patient's interest. Further, if the State wishes to impose a POS requirement where employers do not offer a choice of health plans, then the requirement should be applied to any type of "lock-in" plan, such as exclusive provider organizations (EPOs) or arrangements. There is justification for consumer protections where members are "locked in" to a health system, but these protection should be applicable across-the-board.

Under the Act as presented to the Governor, HMOs will take on a significant new administrative workload--some of which are barriers to efficiency as discussed later--and additional costs. These additional costs will result in higher premiums to HMO enrollees. The additional requirements and added costs combined with the exemption of other forms of managed care including preferred provider organizations (PPOs), EPOs, and integrated delivery systems, appear to insert an unfair disadvantage to HMOs doing business in Maryland. This observation is more fully explained by the following analysis of the Act.

Article 48A - Insurance Code, Section 490BB

The provisions of subsection (B) would require HMOs to maintain a) up-to-date mailing addresses for enrollees (with no responsibility on enrollees to inform the plan of moves), b) systems to track changes in enrollees' choice of primary care physicians (PCPs), and c) systems for notifying individual enrollees of changes in network providers.

Subsection (D) establishes timelines for handling applications to the panel. These performance standards, however, could result in administrative inefficiencies as HMOs attempt to comply with legal deadlines or face penalties. The bill does not appear to contain any flexibility for HMOs to prudently manage the ebb and flow of applications or to hold applications until the HMO begins to "grow" its network in response to enrollment cycles and expansion.

As written, the bill assumes that practitioners will submit enough professional information for HMOs to determine within 30 days whether to pursue acceptance or reject the applicant. Traditionally, credentialing is performed through primary verification. That is, the entity responsible for accepting a practitioner into its organization--whether an HMO, PPO, hospital, etc.--obtains evidence of the applicant's credentials from the issuing source of the credential, e.g., verification of medical education is obtained directly from medical schools and residency programs. National accrediting bodies, such as the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations, as well as draft standards of the National Association of Insurance Commissioners, require health plans to perform primary verification.

The timeframes set forth in the legislation do not reflect that HMOs and the verification agencies employed by HMOs cannot control the response times of the issuing source of information, including medical schools, medical specialty organizations, even the National Practitioner Data Bank.

As a matter of health care quality assurance and consumer protection, we feel that any health plan that enrolls members and sets out a panel of providers for its membership should be required to credential and recredential participating physicians as well as other practitioners providing medical services as permitted by state law.

Subsections (E) and (F) establish protections--many of which already exist in federal law--for applicants to HMO panels.[1] Subsection (G) requires HMOs to establish internal review systems for resolving practitioner grievances and termination disputes. While the standards of accountability established by these requirements are important, the bill may inadvertently create an environment for civil action against HMOs. Rejected applicants would be able to take judicial action against HMOs claiming that they were rejected based on gender, race, age, type of license or certification, etc., not the reason given by the HMO in its written response. Providers dissatisfied with the results of the internal review system could claim that an HMO's review system does not meet the intent of the law. A significant amount of such activity could be counterproductive.

In addition to the increased potential for lawsuits, HMOs would have an administrative burden to always demonstrate that the health plan is acting within the intent of these provisions. HMOs may be pressured into making decisions based on the threat of lawsuits rather than what is best for their enrollees and the health plan, and even lose some cost savings achieved through organizational efficiency. These provisions also may create a "loophole" for physicians who do not meet credentialing standards or who do not cooperate with the plan's utilization and clinical practice guidelines. Thus, without balancing protections for well-meaning HMOs, these provisions may jeopardize legitimate quality assurance activities and the continuous improvement of medical practice within the health plan.

The attention that the Patient Access Act places on continuity of care is laudable. However, the emphasis on an enrollee's right to continue seeing a primary care physician (PCP) for the 90 day period prior to termination from an HMO's panel [subsections (B)

---

[1] Medicare managed care regulations specifically protect the right of contracting health plans to determine the type of practitioner that will provide covered services to enrolled beneficiaries. [see 42 CFR 417.414(c)]

and (J)] causes us some concern for quality of care and enrollee welfare. As written, enrollees will be denied this right if their PCP is being terminated for fraud, patient abuse, or incompetency. This new requirement would place HMOs in a precarious position.

It is difficult and a lengthy process to prove practitioner fraud, abuse, or incompetency. Currently, HMOs are able to act before all evidence is in, or before an investigation is completed, or to use its best judgment on incomplete evidence in order to protect patients. The language of the bill may inadvertently prompt HMOs to delay action until a strong case is built because of the threat of judicial action by physicians facing termination under these circumstances. The bill does not contain any protection for HMOs trying to act in the best interest of their enrollees.

Subsection (J) also requires HMOs to continue paying practitioners at the contracted amount for the 90 days preceding actual termination. Under capitation arrangements, the incentive may be introduced for practitioners to accept payment but withhold services during this 90 day period. This requirement, taken with the previous concern that the Act creates a disincentive for HMOs to quickly terminate fraudulent or poor quality physicians, causes us some additional concern for quality of care.

Section 490CC

Subsection (B) appears to prevent HMOs from using what is termed "withholds," a common and generally accepted risk arrangement. HMOs need flexibility to use various forms of risk-sharing as may be appropriate to control unnecessary and inappropriate use of health care services while assuring that medically necessary covered services are provided. For example, my staff in the Office of Managed Care generally do not permit FQHMOs or Medicare risk contractors to capitate PCPs with less than 100 enrollees, but would permit other types of risk arrangements such as withholds. HMOs commonly use withholds to establish risk pools, a way of spreading a portion of the risk among a group of providers so that no one practitioner is overly vulnerable or overly pressured by the alternative payment methodologies of managed care.

We appreciate the opportunity to comment on this legislation.

Sincerely,

Dale A Drapala for

Rodney C. Armstead, M.D.
Director

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-May-1995 04:51pm

TO: Julie E. Demeo

FROM: Jennifer L. Klein
Domestic Policy Council

CC: Jeremy D. Benami

SUBJECT: RE: Bob Cabe meeting

I think that Diana knows these issues better than I do. Could you ask her if she feels comfortable handling this. If not, I'll figure it out.

Diana —
What happened w/ this — did you ever get this?
What is our next step?
Julie

I think I remember leaving you a voice mail.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-May-1995 02:43pm

TO: Jennifer L. Klein

FROM: Julie E. Demeo
Domestic Policy Council

CC: Jeremy D. Benami

SUBJECT: Bob Cabe meeting

Carol is scheduled to meet with Bob Cabe and others re: their HCFA application and Arkansas' recent passage of any willing provider legislation, and Medicare risk contract situation.

Jeremy wanted me to remind you of this meeting and ask you to check on the status of the HCFA application. We also need to see if it is okay for Carol to meet with them at this point in hte application process (I can call General Counsel once we know more).

You should email Carol with the lastest update and information regarding these issues.

410-966-8060
House - 50 state

Sen - 50 st -
18 mos.

direct to monitor closely

From HCFA

Managed Care Issues

1. Medicare Risk Contract

On May 1, HCFA's Office of Managed Care sent HMO Arkansas (AR BC/BS's HMO) a letter requesting additional information because their Medicare risk contract application was incomplete. Once the additional information is received, a decision on the application will follow within 60 days. [Note: Aside from needing additional information, thus far, no major problems with their application have arisen.]

2. Medicare SELECT

Arkansas is not one of the 15 designated states in the Medicare SELECT demonstration. Therefore, AR BC/BS cannot participate in the program as it currently operates. The Senate passed legislation today, already passed by the House, extending the SELECT program and expanding it to all 50 states. If signed by the President, AR BC/BS could conceivably participate; the Administration however, has expressed opposition to the SELECT extension/expansion due to inadequate consumer protections and quality of care safeguards. Further, the evaluation of the SELECT demonstration will not be complete until this fall, giving us little idea at this point of the program's value. We support a 12-month extension of the 15-state demonstration in order to review the evaluation. Our preference is to replace SELECT with a Medicare "Preferred Provider Option" (PPO). [HCFA's legislative proposal for the PPO is currently pending at OMB.]

- o AR BC/BS may well like the PPO option if they are interested in SELECT (fewer restrictions than the Medicare risk program). PPOs were the insurance industry's response to the rise of HMO and the Blues are heavily into the PPO market.

3. Medicare Budget Cuts

Medicare budget cuts of the size being discussed in Congress would have significant impact on the Medicare managed care program. Increases in beneficiary copayments and deductibles and reductions in payments to providers would place downward pressure on the AAPCC (which is calculated on historical fee-for-service claims data), resulting in much lower payments to Medicare risk contractors. This will likely result in zero- or low-premium Medicare plans (over 50% of Medicare contractors offer zero-premium products) being forced to increase their premiums and/or cut supplemental benefits, such as prescription drugs or eyeglasses -- the principal incentives for Medicare beneficiaries to enroll in managed care plans. The effect would be the opposite of Congress' intent: fewer Medicare beneficiaries joining HMOs, and more leaving them.

4. Any Willing Provider

By Federal law, Federally Qualified HMOs are protected from restrictive state laws; further,

hasn't been tested in court

Medicare managed care regulations specifically protect the right of contracting health plans to determine the type of practitioner that will provide covered services to enrolled beneficiaries. HCFA, commenting on laws passed by Maryland and Virginia similar to the one about to be enacted in Arkansas, stated that these provisions pre-empted state "any willing provider" laws. [copies of the letters and a press report of the letters are attached]

Any Willing Provider Laws

HCFA: Va. ancillary provider law makes HMOs too much like FFS plans

A potentially new strain of any willing provider law may have been snuffed out by the Health Care Financing Administration. The agency has ruled that federally qualified HMOs in Virginia are not allowed to comply with a state law HCFA says would strip them of the ability to manage care by forcing them to cover unrestricted ancillary services.

The situation was brought to HCFA's attention by the Kaiser Foundation Health Plan. In a letter to Rodney C. Armstead, director of HCFA's Office of Managed Care, Judith M. Mears, Kaiser's vice president and assistant general counsel, cited a 1988 amendment to the HMO Act that allowed FQHMO members to receive no more than 10% of non-emergency services from providers not affiliated with the HMO.

"The amendment reflects Congress' concern that permitting more than 10% of an HMO's services to be obtained outside the plan would compromise a basic characteristic of federally qualified HMOs," Mears said. If they could not be solely responsible for the majority of an enrollee's care, FQHMOs could not conform to that part of the HMO Act that charges them with protecting enrollees when they receive medical services, she added. Further, the Virginia law "mandates an HMO to adopt indemnity-like characteristics in violation of the HMO Act and the essential character of prepaid FQHMOs."

In his response to Mears' letter, Armstead questioned whether HMOs that followed the law could even be considered HMOs. "While not in our jurisdiction, we also anticipate that the Internal Revenue Service may question the tax-exempt status of non-profit FQHMOs in Virginia because of the shift in the nature of the plan toward insurance," he added.

What's the next step? "That's the $64,000 question," says Sarah Hopkins Finley, an attorney with Williams, Mullen, Christian & Dobbins, Richmond. She says the state legislature is entertaining one bill to repeal the provision entirely and one to restrict qualified ancillary service providers to those who have previously notified the HMO of their agreement to accept patients at rates paid participating ancillary service providers.

Legislation to repeal the provision has passed the state House of Delegates and will be taken up by the Senate soon. The state's Joint Commission on Health Care has been assigned to study the issue over the next three years. Call Finley at (804)783-6481 for details.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Director's Office
Washington, D.C. 20201

DEC - 5 1994

Judith M. Mears
Vice President and Assistant
General Counsel
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, California 94612

Dear Ms. Mears:

We have reviewed your November 7, 1994, letter (and attachments) representing the concerns of Kaiser Foundation Health Plan of Mid-Atlantic States regarding recently enacted legislation by the Commonwealth of Virginia.

We believe that Federally qualified health maintenance organizations (FQHMOs) do not have to comply with the law at issue, Chap. 963 of the Acts of the General Assembly of Virginia, 1994 House Bill 840 (referred to as Chap. 963), with regard to payment for ancillary services because this law is in conflict with portions of Title XIII of the Public Health Service Act (the HMO Act) and implementing regulations at 42 CFR 417.

The HMO Act and regulatory provisions governing FQHMOs require participating health plans to provide or arrange for all basic health services, with the exception of medical emergencies. (See 42 U.S.C. 300e, 300e-1; 42 CFR 417.103) The HMO Amendments of 1988, P.L. 10-517, allows FQHMOs to offer a self-referral option for physician services, i.e., enrollees may seek care from non-plan physicians within guidelines established by the FQHMO. This statutory provision sets a 10 percent "cap" on out-of-plan physician services and does not permit out-of-plan ancillary services, at least not in the broad, undefined context of Chap. 963. As you know, the 1988 Amendments were considered self-implementing, but a notice of proposed rule making on the self referral option has been published and a final rule is under development. Compliance with Chap. 963 would require HMOs to permit practices that would violate the above Federal requirements.

We also believe that 42 U.S. C. 300e-10 is applicable in this situation. This provision of the HMO Act states:

> In the case of an entity--
>
> (1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise--

> . . . (E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, and
>
> (2) . . . which is a qualified health maintenance organization for purposes of section 300e-9 of this title,
>
> such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e-9 of this title.

The Virginia law in question would prevent an FQHMO from providing and arranging for basic health services as discussed previously. Further, in that the definition of an HMO involves the interrelationship of providing comprehensive benefits in-plan, risk sharing with providers, utilization management through plan-established practice guidelines, and quality assurance mechanisms (including grievance and appeal procedures), Chap. 963 has the effect of undermining the very nature of a prepaid health plan and shifting consideration of these entities toward that of an indemnity insurance product. HCFA will have to question whether FQHMOs complying with ancillary services provisions of Chap. 963 could be considered HMOs. While not in our jurisdiction, we also anticipate that the Internal Revenue Service may question the tax-exempt status of non-profit FQHMOs in Virginia because of the shift in the nature of the plan toward insurance.

While there are a number of policy concerns about the Virginia law--such as the implementation and impact of Chap. 963 under capitated payment arrangements, the impact on fiscal soundness and insolvency protection, and the weakening of continuity and care management--we are limiting this letter to the serious legal concerns involved with this state legislation.

Sincerely,

Rodney C. Armstead, M.D.
Director

cc:
Bruce Vladeck

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Director's Office
Washington, D.C. 20201

MAY 11 1995

Charles W. Stellar
President
American Managed Care and Review Association
1227 25th Street, NW, Suite 610
Washington, D.C. 20037-1156

Dear Mr. Stellar:

Your organization is concerned about the impact on health maintenance organizations (HMOs) of certain legislation under consideration in the state of Maryland. In particular, you are concerned about the impact that the Patient Access Act now before the Governor, may have on federally qualified HMOs (FQHMOs). We have reviewed the enrolled bill and have the following comments.

FQHMO Compliance with the HMO Act

Section 19-710.2 of the Patient Access Act (as enrolled) requires HMOs to make a point-of-service (POS) option available to employees and individuals who have no other option of receiving health benefits through their employer, association or private group. We believe this provision could be in conflict with the Title XIII of the Public Health Service Act (the HMO Act), specifically the self-referral option enacted by Congress in the HMO Amendments of 1988 (P.L. 100-517). Under the HMO Act, FQHMOs may offer a "self-referral option" for physician services, i.e. enrollees may seek care from non-plan physicians within guidelines established by the FQHMO. This statutory provision sets a 10 percent "cap" on out-of-plan physician services. Other services, such as hospital care, can be obtained out-of-plan only if permitted and preauthorized by the FQHMO. As you know, the 1988 Amendments were considered self-implementing, but a notice of proposed rulemaking on the self-referral option has been published and a final rule is under development.

Although there is a provision in the Maryland legislation that limits the applicability of the POS requirement to FQHMOs to the extent permitted under federal law, the mandate could put a FQHMO in jeopardy of exceeding the 10 percent limit. The enrolled bill does not specifically provide FQHMOs with a waiver to cease offering the POS option to eligible employees if it reaches the 10 percent "cap." The bill also does not address whether these employers, associations, and private groups would take precedent over the FQHMO's other commercial, Medicaid, and Medicare enrollments in having the POS product available. The Office of Managed Care anticipates monitoring the 10 percent limit across all product lines of a FQHMO, not on a contract by contract basis.

Federal Preemption Authority

Section 1311 of the HMO Act (42 U.S.C. 300e-10) provides FQHMOs with protection from restrictive state laws. While the requirements of the Patient Access Act do not appear to invoke any provisions of this section, we cannot comment conclusively at this time. In developing regulations, State officials will make policy interpretations, and it is possible that some of the regulatory requirements may be in conflict with Section 1311.

Below, we take the opportunity to provide additional comments on the Maryland Patient Access Act.

Creation of an "Unlevel Playing Field"

The Patient Access sets forth certain accountability requirements and higher performance standards, but only on one segment of the managed care industry. It appears to us that any health care system which establishes a panel of providers and which sets financial incentives for members to obtain services from that panel, including preferred provider organizations, exclusive provider organizations, and integrated delivery systems, should be required along with HMOs to:

- meet the application and processing requirements for provider applicants as set forth in the bill and be subject to penalties for failure to comply,
- make efforts to include minority providers,
- not deny participation on the basis of gender, race, age, religion, national origin, or certain disabilities, or based on the provider's grievance history,
- have an internal review system to hear disputes of providers being terminated from the plan panel,
- provide a current list of providers and information as to which participating providers are "full" (not accepting new members) and to existing members at least once a year,
- provide clear information to members as to how to file a complaint about the plan with State officials,
- keep panel members informed of terminations (as well as which members of specialty practices are participating), and
- notify members in advance when providers are being terminated from the panel.

In addition, any managed health care plan that applies utilization review and management techniques should have internal

review systems to hear provider grievances and allow providers to advocate in the patient's interest. Further, if the State wishes to impose a POS requirement where employers do not offer a choice of health plans, then the requirement should be applied to any type of "lock-in" plan, such as exclusive provider organizations (EPOs) or arrangements. There is justification for consumer protections where members are "locked in" to a health system, but these protection should be applicable across-the-board.

Under the Act as presented to the Governor, HMOs will take on a significant new administrative workload--some of which are barriers to efficiency as discussed later--and additional costs. These additional costs will result in higher premiums to HMO enrollees. The additional requirements and added costs combined with the exemption of other forms of managed care including preferred provider organizations (PPOs), EPOs, and integrated delivery systems, appear to insert an unfair disadvantage to HMOs doing business in Maryland. This observation is more fully explained by the following analysis of the Act.

Article 48A - Insurance Code, Section 490BB

The provisions of subsection (B) would require HMOs to maintain a) up-to-date mailing addresses for enrollees (with no responsibility on enrollees to inform the plan of moves), b) systems to track changes in enrollees' choice of primary care physicians (PCPs), and c) systems for notifying individual enrollees of changes in network providers.

Subsection (D) establishes timelines for handling applications to the panel. These performance standards, however, could result in administrative inefficiencies as HMOs attempt to comply with legal deadlines or face penalties. The bill does not appear to contain any flexibility for HMOs to prudently manage the ebb and flow of applications or to hold applications until the HMO begins to "grow" its network in response to enrollment cycles and expansion.

As written, the bill assumes that practitioners will submit enough professional information for HMOs to determine within 30 days whether to pursue acceptance or reject the applicant. Traditionally, credentialing is performed through primary verification. That is, the entity responsible for accepting a practitioner into its organization--whether an HMO, PPO, hospital, etc.--obtains evidence of the applicant's credentials from the issuing source of the credential, e.g., verification of medical education is obtained directly from medical schools and residency programs. National accrediting bodies, such as the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations, as well as draft standards of the National Association of Insurance Commissioners, require health plans to perform primary verification.

The timeframes set forth in the legislation do not reflect that HMOs and the verification agencies employed by HMOs cannot control the response times of the issuing source of information, including medical schools, medical specialty organizations, even the National Practitioner Data Bank.

As a matter of health care quality assurance and consumer protection, we feel that any health plan that enrolls members and sets out a panel of providers for its membership should be required to credential and recredential participating physicians as well as other practitioners providing medical services as permitted by state law.

Subsections (E) and (F) establish protections--many of which already exist in federal law--for applicants to HMO panels.[1] Subsection (G) requires HMOs to establish internal review systems for resolving practitioner grievances and termination disputes. While the standards of accountability established by these requirements are important, the bill may inadvertently create an environment for civil action against HMOs. Rejected applicants would be able to take judicial action against HMOs claiming that they were rejected based on gender, race, age, type of license or certification, etc., not the reason given by the HMO in its written response. Providers dissatisfied with the results of the internal review system could claim that an HMO's review system does not meet the intent of the law. A significant amount of such activity could be counterproductive.

In addition to the increased potential for lawsuits, HMOs would have an administrative burden to always demonstrate that the health plan is acting within the intent of these provisions. HMOs may be pressured into making decisions based on the threat of lawsuits rather than what is best for their enrollees and the health plan, and even lose some cost savings achieved through organizational efficiency. These provisions also may create a "loophole" for physicians who do not meet credentialing standards or who do not cooperate with the plan's utilization and clinical practice guidelines. Thus, without balancing protections for well-meaning HMOs, these provisions may jeopardize legitimate quality assurance activities and the continuous improvement of medical practice within the health plan.

The attention that the Patient Access Act places on continuity of care is laudable. However, the emphasis on an enrollee's right to continue seeing a primary care physician (PCP) for the 90 day period prior to termination from an HMO's panel [subsections (B)

---

[1] Medicare managed care regulations specifically protect the right of contracting health plans to determine the type of practitioner that will provide covered services to enrolled beneficiaries. [see 42 CFR 417.414(c)]

and (J)] causes us some concern for quality of care and enrollee welfare. As written, enrollees will be denied this right if their PCP is being terminated for fraud, patient abuse, or incompetency. This new requirement would place HMOs in a precarious position.

It is difficult and a lengthy process to prove practitioner fraud, abuse, or incompetency. Currently, HMOs are able to act before all evidence is in, or before an investigation is completed, or to use its best judgment on incomplete evidence in order to protect patients. The language of the bill may inadvertently prompt HMOs to delay action until a strong case is built because of the threat of judicial action by physicians facing termination under these circumstances. The bill does not contain any protection for HMOs trying to act in the best interest of their enrollees.

Subsection (J) also requires HMOs to continue paying practitioners at the contracted amount for the 90 days preceding actual termination. Under capitation arrangements, the incentive may be introduced for practitioners to accept payment but withhold services during this 90 day period. This requirement, taken with the previous concern that the Act creates a disincentive for HMOs to quickly terminate fraudulent or poor quality physicians, causes us some additional concern for quality of care.

Section 490CC

Subsection (B) appears to prevent HMOs from using what is termed "withholds," a common and generally accepted risk arrangement. HMOs need flexibility to use various forms of risk-sharing as may be appropriate to control unnecessary and inappropriate use of health care services while assuring that medically necessary covered services are provided. For example, my staff in the Office of Managed Care generally do not permit FQHMOs or Medicare risk contractors to capitate PCPs with less than 100 enrollees, but would permit other types of risk arrangements such as withholds. HMOs commonly use withholds to establish risk pools, a way of spreading a portion of the risk among a group of providers so that no one practitioner is overly vulnerable or overly pressured by the alternative payment methodologies of managed care.

We appreciate the opportunity to comment on this legislation.

Sincerely,

Dale A Diapala for

Rodney C. Armstead, M.D.
Director