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Physician Perspectives of Medicare HMOs

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EXECUTIVE SUMMARY

PURPOSE

To determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs).

BACKGROUND

The Office of Inspector General (OIG) has issued numerous reports on Medicare HMOs over the past several years. Some of these reports have raised concerns with the impact of HMOs on the access and quality of health care provided to Medicare beneficiaries.

An HMO is a type of managed care plan that both provides and insures a set of health care services for enrollees. Medicare beneficiaries have the option of receiving health care either from private providers on a fee-for-service basis or from an HMO with an approved Health Care Financing Administration (HCFA) contract. These HMOs are required to contract with sufficient numbers of providers, including physicians, to enable them to provide adequate access and continuity of care to their Medicare enrollees. As of April 1, 1997, 5.2 million beneficiaries (approximately 13.7 percent of the total Medicare population) were members of one of 378 HMOs, up from 4.5 million in 325 plans as of September 1, 1996.

We used three methods of data collection for this inspection. First, we sent a mail questionnaire to a stratified random sample of 2,500 physicians in June 1997. We received questionnaires from 1,140 physicians, for an overall response rate of 46 percent. Of the 1140 questionnaires returned to us, 449 were from physicians with Medicare HMO contracts. All percentages reported in our findings are based on these 449 physicians. Second, we conducted structured telephone interviews with 25 physicians who volunteered to be called for a follow-up interview. Third, we reviewed five contracts sent to us by the physicians we interviewed by telephone.

This report makes no comparison to physicians' perceptions of the health care provided in a fee-for-service setting, since no comparable survey work has yet been conducted in this area. While this report confirms many commonly expressed concerns regarding HMOs, it also contributes additional insights into these concerns from Medicare HMO physicians.

FINDINGS

Overall Physician Satisfaction With Medicare HMOs Is Low

Close to one-half of physicians with Medicare HMO contracts (43 percent) say they are very or somewhat dissatisfied with the Medicare HMO, while just 18 percent are somewhat or very satisfied. The remaining 39 percent are neither satisfied nor dissatisfied. Half of the physicians who are salaried HMO employees (13 of 27) are satisfied overall, compared to just 16 percent of

all other physicians.

Many Physicians Report Concerns With Medicare HMOs

Referral Process

When reporting on referral times, 79 percent of physicians who need prior approval for referrals usually wait 5 or more minutes to get through when calling the HMO for their referral; 16 percent wait 1 to 3 days for the HMO to reach a decision, and 12 percent wait longer than 1 week. Close to half of physicians (42 percent) are dissatisfied with the HMO referral process.

Clinical Independence

A majority of physicians (62 percent) believe that working in a Medicare HMO often or sometimes restricts their clinical independence. At least one-quarter say the HMO's concern with costs always or frequently influences their referrals for specialists or tests, post-acute arrangements, and general treatment decisions.

Access To Care

Some physicians believe Medicare HMOs limit their patients' access to care. In particular, a large majority say that fee-for-service is better than HMOs for access to specialists (74 percent) and for access to new treatments (69 percent). Additionally, 29 percent think referral restrictions are worse for Medicare HMOs than for all HMOs in general, and 27 percent say they often feel restricted in referring their Medicare HMO patients for specialists and tests. A few volunteer other problems specific to caring for HMO Medicare patients, such as the greater complexity of their health care needs, their susceptibility to dishonest HMO marketing practices, and their inability to understand and work the HMO system to their advantage.

Complaints And Appeals

Forty percent of physicians are dissatisfied with the way the HMO handles their complaints, and 30 percent are dissatisfied with the formal appeals process. As their dissatisfaction with these procedures decreases, so too does their overall satisfaction with the Medicare HMO. Only one-quarter (28 percent) have ever formally appealed an HMO decision, and one-half (53 percent) are generally not satisfied with how their complaints are resolved.

Utilization And Quality Assurance Reviews

While not required by regulation, less than half (40 percent) of physicians say they have ever had a utilization and quality assurance review. Thirty-seven percent report never having one of these reviews and the remaining 23 percent do not know if they have had one. Of those physicians who say they have had such reviews, three-quarters (73 percent) say they were done appropriately, but less than half (43 percent) say they were used appropriately.

Marketing Practices

A few physicians are concerned that Medicare beneficiaries are particularly susceptible to questionable HMO marketing practices. Of the fifty-five physicians who report observing fraud in a Medicare HMO, eleven report dishonest marketing practices. The other fraudulent practices reported by physicians but not related to marketing include delaying or denying medically necessary services and overbilling.

Most Physicians Rate Medicare Enrollee Knowledge Of Their HMO Low

Most physicians believe that Medicare enrollees do not understand core elements of their HMO, such as the referral process (70 percent), benefits (75 percent), restrictions on services (83 percent), and the appeals and grievance process (89 percent). Physicians' perceptions of Medicare enrollee knowledge and HMO referral times are linked to their perceptions of quality of care. They believe quality of care decreases as Medicare enrollee knowledge decreases or referral time increases.

Despite The Misgivings Cited Above, Most Physicians Believe That Their Medicare Patients Receive Good Care

A majority of physicians (71 percent) report that the overall quality of care Medicare enrollees get at their HMO is excellent or good; another 21 percent rate the care as fair, while the remaining 8 percent say it is poor or very poor. Similarly, most physicians (62 percent) are satisfied with their relationships with their Medicare patients. Furthermore, nearly all (90 percent) believe they spend an adequate amount of time with them during office visits.

CONCLUSION

Needless to say, HCFA should work with physicians to address their concerns about Medicare HMOs and to improve the quality of services provided to Medicare HMO enrollees. We believe that greater physician satisfaction with the Medicare HMO program will enhance both enrollees' and providers' experiences with that program.

This survey identifies the issues which most concern Medicare HMO physicians, many of which are general in nature, such as a lack of clinical independence and restrictions on access to care. Such concerns are most likely to be resolved through overall improvement of the HMO program.

However, there are other distinct concerns we believe might be more amenable to specific solutions. In particular, physicians expressed the following concerns:

- the appeals process
- beneficiary knowledge
- the referral process
- utilization and quality assurance reviews

We believe that the implementation of the 1997 Balanced Budget Act "MedicarePlus" program provides HCFA with an opportunity to address physicians' concerns about the lack of beneficiary HMO knowledge. This program gives beneficiaries the option of receiving their Medicare benefits through MedicarePlus plans, which would include HMOs and other coordinated plans such as Preferred Provider Organizations (PPOs). These plans will be required to provide specific information to beneficiaries at enrollment, and annually thereafter, about certain plan features such as quality of care, utilization reviews, and procedures for appeals and grievances.

Other approaches HCFA may want to consider in addressing these issues include establishing HMO performance standards, such as for referral times and utilization and quality assurance reviews. It may be necessary to conduct further studies of specific areas of concern. Whatever approach is used, we believe a process of consultation between HCFA and physician groups would be a good first step towards resolving some of their concerns.

The OIG plans to periodically repeat this physician survey to determine if progress is being made in improving physician satisfaction. We also plan to continue our surveys of Medicare beneficiaries to obtain their experiences and satisfaction with their HMOs.

COMMENTS

We received comments on the draft report from HCFA. They concur with our general observations and conclusion and state that the Balanced Budget Act of 1997 addresses many of the physicians' concerns reported in our study. Both the Assistant Secretary for Management and Budget (ASMB) and HCFA provided technical comments, which have been incorporated into the final report when appropriate.

The HCFA suggests that we remove a reference in our conclusion to prior OIG recommendations on strengthening the appeals and grievance procedures for beneficiaries. We agree with their suggestion and have removed this reference from our report.

The HCFA also notes that our report does not indicate whether physician experience with Medicare HMOs differs from their experience with non-Medicare HMOs and suggests that it would be helpful to conduct a comparable survey of physicians about the Medicare fee-for-service system. We agree that it would be useful to study these comparisons; however, such analysis was not within the scope of our work.

The full comments from HCFA are presented in Appendix F.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY

INTRODUCTION 1

FINDINGS 6

Overall Physician Satisfaction With Medicare HMOs Is Low 6

Physicians Report Concerns with Medicare HMOs 7

Physicians Rate Medicare Enrollee Knowledge of HMO Low 11

Despite Misgivings, Physicians Believe Medicare Patient Care Is Good 12

CONCLUSION 14

APPENDICES

A: Sample Selection A-1

B: Profile of Medicare HMO Physicians B-1

C: Non-respondent Analysis C-1

D: Confidence Intervals for Key Survey Questions D-1

E: Statistical Tests for Key Findings E-1

F: Comments F-1

INTRODUCTION

PURPOSE

To determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs).

BACKGROUND

The Office of Inspector General (OIG) has issued numerous reports on Medicare HMOs over the past several years. Some of these reports have raised concerns with the impact of HMOs on the access and quality of health care provided to Medicare beneficiaries. These previous studies have surveyed only Medicare HMO enrollees and administrators. This survey obtains the perspectives of another important player in the Medicare HMO industry, the physician.

The HMO Industry

A health maintenance organization (HMO) is a type of managed care plan that both provides and insures a set of health care services for enrollees. Most HMOs operate on a gatekeeper system, in which a patient selects a primary care physician from a group of approved plan providers to act as her or his first point of contact within the health care system. This physician must authorize any specialist, hospital, or other type of care the patient receives.

Three basic models currently dominate the HMO market. In the first, a staff model, physicians practice solely as employees of the HMO and normally are paid a set salary. In the second, a group model, the HMO contracts with medical groups to provide specific covered services in exchange for a negotiated payment which is then distributed among the group's physicians. Finally, an individual practice association (IPA) contracts with individual physicians who then see patients in their private practices. Unlike those in staff models, physicians in IPA and group HMOs can participate in multiple managed care plans.

Medicare HMOs

In certain geographical areas, Medicare beneficiaries have the option of receiving health care either from private providers on a fee-for-service basis or from an HMO. To participate in the Medicare program, an HMO must apply for either a risk or a cost contract from HCFA. Both contracts require the HMO to provide all services covered by Parts A and B of Medicare. Those HMOs with risk contracts are paid on a prospective per capita basis. They receive a set premium per Medicare enrollee, regardless of how much care each patient actually receives. Risk plans must assume financial responsibility for providing all necessary covered services to Medicare enrollees. They are required to absorb any financial losses, but are permitted to retain any savings. Cost plans are paid on a reasonable cost basis, with adjustments made at the end of the year for variations from the predicted budget.

Growth in Medicare HMOs

The Medicare HMO program has experienced rapid growth over the past several years, adding new enrollees at a rate of more than 80,000 per month in 1996. As of April 1, 1997, 5.2 million beneficiaries (approximately 13.7 percent of the total Medicare population) were members of one of 378 HMOs, up from 4.5 million in 325 plans as of September 1, 1996. Participation in risk plans accounts for most of the recent growth in Medicare HMOs. Enrollment in HMO plans varies greatly among geographic locations. The proportion of beneficiaries in Medicare HMOs ranges from over 35 percent in California and Arizona, to none in several other States.

Physicians in HMOs

An HMO can choose among several methods by which to pay its affiliated physicians. First, the physicians can be paid a set salary which is independent of the number of patients treated and services utilized. Alternatively, physicians may receive payment on a capitation basis. Under this system the physician is paid a fixed rate per HMO member, regardless of the amount of care each patient actually receives. Providers can also be paid on a fee-for-service basis, in which they are compensated for actual services rendered. It is possible for a plan to pay some providers by capitation and others by fee-for-service.

The HCFA regulations state that a Medicare HMO is required to contract with sufficient numbers and types of providers to enable it to provide health care services which will assure adequate access and continuity of care to its enrollees. The HMO can exercise its own discretion in determining provider payment methods and work requirements. However, to meet HCFA requirements, the following six points must be included in its provider contracts:

1. The provider must agree to serve the HMO members for a specific period of time.
2. The provider must agree to provide services to commercial and Medicare members.
3. The provider must agree not to bill HMO members.
4. The provider must agree to be reviewed by the utilization management and quality assurance staff of the HMO.
5. Payments for services and incentive arrangements, if any, must be stated.
6. The contract must be signed and dated by both the HMO and the provider.

Prior Physician Surveys

Several studies have reported on physicians' perceptions of managed care in general but none have specifically surveyed physicians about the Medicare HMO program. The Physician Payment Review Commission (PPRC), in its Annual Report To Congress, 1994, found that 32 percent of physicians report serious problems in external review and limitations under capitated plans, while only 14 percent under Medicare fee-for-service report similar serious problems. Physicians' Weekly reported an AMA study of 1,010 physicians in 1996 which concluded that a majority of doctors feel that managed care is having a negative impact on the quality of care and impairing the doctor-patient relationship and that managed care is having a negative impact on

the clinical independence of doctors. On the positive side, the AMA survey also reported that many of the physicians see HMOs as having a positive effect on the affordability of health care and on preventive health care.

A 1997 Commonwealth Fund report based on telephone interviews with a national sample of 1,710 physicians reached similar conclusions. Physicians perceive that managed care negatively affects their time spent with patients, their ability to make good clinical decisions, and their ability to keep up with practice guidelines. Satisfaction rates were higher among physicians in group or staff model HMOs than those in other types of plans, such as IPAs.

Prior OIG HMO Surveys

The OIG Office of Evaluation and Inspections has been actively evaluating Medicare HMOs. "Medicare HMO Appeal and Grievance Processes Overview," OEI-07-94-00280, and three other related inspections on the Medicare HMO appeal and grievance processes reported problems in how HMOs implement requirements regarding appeals and grievances, including ineffective communication with Medicare enrollees. Another report, "Medicare's Oversight of Managed Care: Monitoring Plan Performance," OEI-01-96-00190, found limitations in HCFA's oversight of managed care plans. Additionally, the OIG is currently completing a survey of Medicare HMO enrollees, "Beneficiary Perspectives of Medicare Risk HMOs," OEI-06-96-00430. This survey found, among other things, that most enrollees give favorable overall ratings to their primary doctors and HMOs but rate the ease of getting needed care under HMO rules less favorably. Future HMO work planned for the OIG includes a study of marketing practices of Medicare managed care plans.

METHODOLOGY

Multiple Data Collection Methods

We used three methods of data collection for this inspection. First, we sent a mail questionnaire to a stratified random sample of 2,500 physicians. Second, we conducted structured telephone interviews with 25 physicians who volunteered to be called for follow-up interviews. Third, we reviewed five contracts sent to us by some of these physicians.

Physician Mail Survey

We were unable to specifically identify physicians with Medicare HMO contracts because neither the Unique Physician Identification Number (UPIN) file nor any other HCFA database identifies these physicians. We, therefore, selected a stratified random sample of 2,500 physicians from the UPIN file of all physicians who are paid under the Medicare program. In order to maximize the number of physicians with Medicare HMO contracts, we eliminated States with no Medicare HMOs. We then stratified our sample into two groups -- those from States with high Medicare HMO enrollment and those from States with low Medicare HMO enrollment. The 13 States with high enrollment account for 84 percent of Medicare HMO

enrollment nationwide. We selected 1,500 physicians from the high stratum and 1,000 physicians from the low stratum, excluding non-medical doctors such as chiropractors and podiatrists, residents and interns, and pediatricians. See Appendix A for further discussion of the physician sample selection.

We then sent a questionnaire to each of these 2,500 physicians in June 1997. The questionnaire had a filter question which asked the physician if he or she had a current or recent (within the past year) contract with a Medicare HMO. Physicians with such a contract were instructed to fill out the questionnaire. Those without a Medicare HMO contract were asked to return the questionnaire indicating they had no such contract.

After 8 weeks of data collection, during which time we conducted a second mailing to non-respondents, 1,140 questionnaires were returned to us, for an overall response rate of 46 percent. Additionally, we were unable to locate 187 of the 2,500 physicians. Our response rates between strata were almost identical: 45 percent for the high stratum and 46 percent for the low stratum. This response rate, while less than 50 percent, compares favorably to the lower response rates achieved in prior physician surveys discussed in the background.

Of the 1,140 questionnaires returned to us, 449 were from physicians with Medicare HMO contracts. All percentages reported in our findings are based on these 449 physicians. The other 691 physicians we heard from had no Medicare HMO contract. Of the 449 Medicare HMO physicians, 328 were from the high stratum and 121 were from the low stratum. We weighted the data collected from these 449 surveys by stratum. See Appendix B for a profile of the responding Medicare HMO physicians.

While relatively good for a survey of physicians, our response rate of 46 percent suggests the possibility of non-response bias. We attempted to conduct a follow-up telephone survey with 150 randomly selected non-responding physicians, but were able to complete interviews with only five of them. However, we did conduct a non-respondent analysis of all 2,500 physicians in our sample by analyzing several variables which may have influenced responses. See Appendix C for this analysis.

All differences reported between subgroups are statistically significant at the 95 percent confidence level. See Appendix D for confidence intervals for key survey questions and Appendix E for statistical tests for key findings.

Physician Telephone Interviews and Contract Review

On the mail questionnaire, we asked physicians if they would be willing to be called for a follow-up telephone interview. Seventy-nine physicians volunteered. We attempted to reach all of these physicians at least twice, and completed interviews with 25 of them. Our telephone interviews collected additional qualitative data to supplement our mail survey.

We also asked each of the 25 physicians we interviewed for a copy of their Medicare HMO

contract. Some were reluctant to share these with us. We obtained five contracts which we reviewed, looking at both overall content and specific clauses which illustrated some of the issues cited by physicians in the mail survey.

Reporting Findings

The reader should keep two points in mind while reading this report. First, this report makes no comparison to physicians' perceptions of the health care provided in a fee-for-service setting, since no comparable survey work has yet been conducted in this area. Second, while this report confirms many commonly expressed concerns regarding HMOs, it also contributes additional insights into these concerns from Medicare HMO physicians.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

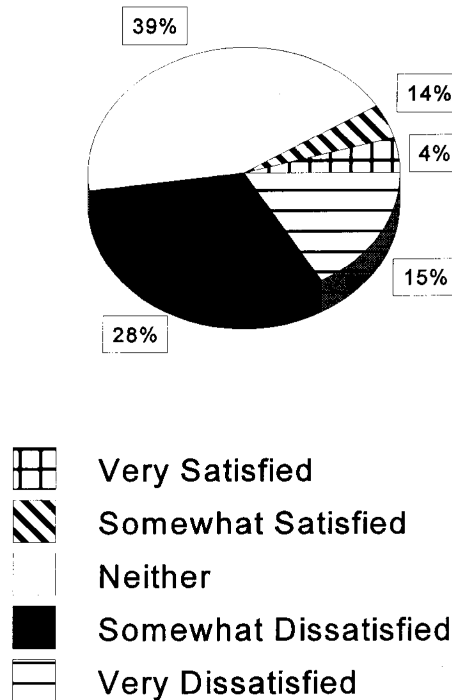
OVERALL PHYSICIAN SATISFACTION WITH MEDICARE HMOs IS LOW

Close To Half Are Dissatisfied Overall

When asked to rate their overall satisfaction with their Medicare HMO, physicians report low levels of satisfaction, as illustrated in Graph A below. Forty-three percent of physicians say they are very or somewhat dissatisfied with their HMO.

On the other hand, just 18 percent of physicians are somewhat or very satisfied, and the remaining 39 percent report that they are neither satisfied nor dissatisfied. These findings are similar to findings from other physician surveys noted in the background.

Graph A
Proportion Of Physicians Satisfied With Medicare HMOs



Satisfaction varies among different groups of physicians. Half of the physicians who are salaried HMO employees (13 of 27) are satisfied overall, compared to 11 percent of physicians in solo practice and 16 percent of physicians in group practice. Similarly, physicians who are on the staff of an HMO are more satisfied overall (38 percent) than those who see their Medicare HMO patients in their private practices (17 percent). It appears that physicians employed full-time by a

Medicare HMO view it differently than physicians who work with the HMO on only a part-time basis, perhaps because they are more familiar with the HMO's operations or are more invested in its success. Finally, 50 percent of specialists are dissatisfied with HMOs, compared to just 29 percent of primary care physicians.

Satisfaction does not vary by other physician characteristics. Physicians' satisfaction levels do not appear to differ significantly based on the number of years they have been in practice or based on the size of their Medicare HMO practices. Satisfaction levels are also similar between physicians from States with high Medicare HMO enrollment and those from States with low enrollment.

MANY PHYSICIANS REPORT CONCERNS WITH MEDICARE HMOs

Confirming general opinion, physicians report several concerns with Medicare HMOs. These range from operational issues such as referral practices, to restrictions on their clinical independence. These concerns are linked to physicians' overall dissatisfaction with Medicare HMOs.

Referral Process

A majority of physicians have some experience with their Medicare HMO's referral process. Sixty-four percent routinely refer their Medicare patients to specialists or for tests, and most of them need prior approval for their referrals.

Most physicians (79 percent) wait 5 or more minutes to get through to the HMO when calling for approval of referrals; 30 percent of these wait more than 30 minutes. One physician exclaims that "every time our office calls [the HMO] we are placed on hold for an average of 45 minutes!" Tables A below illustrates the length of time it takes physicians to get through when calling their HMO for approval of referrals.

Table A

Length Of Time To Get Through To HMO When Calling For Approval

Right away	Less than 5 minutes	5 to 30 minutes	More than 30 minutes
6%	15%	49%	30%

One quarter (27 percent) of physicians wait 3 or more days for the HMO to make a decision on their referrals. Table B below illustrates the length of time for HMOs to make this decision.

Table B
Length Of Time For HMO To Make Decision

Within 1 hour	Within 1 day	1 to 3 days	3 to 7 days	More than 7 days
14%	26%	33%	16%	11%

Physicians note that the referral process varies widely among Medicare HMOs. This lack of uniformity in paperwork and procedures may create additional administrative work. Not surprisingly, a majority of physicians (82 percent) say they would favor a uniform referral process among all Medicare HMOs.

Physicians who are salaried employees of HMOs report fewer problems with the referral process than physicians in other types of practices. Nearly half of salaried HMO physicians (12 of 27) do not need HMO approval prior to referring their Medicare HMO patients for specialists or tests. Of those who need pre-certification, three-quarters are able to get through to an HMO representative within 5 minutes, compared to less than one-quarter of physicians in other types of practices.

Forty-two percent of physicians are somewhat or very dissatisfied with the HMO referral process. As physician satisfaction with this process decreases, so too does their overall satisfaction with the Medicare HMO. A majority (81 percent) who are satisfied with the HMO referral process are also satisfied overall, while just 7 percent of those dissatisfied with the referral process report being satisfied overall.

Three of the physicians we interviewed by telephone volunteer that they are required to refer patients to poor quality providers (e.g., radiology groups, medical equipment suppliers) just because these providers have contracts with the HMO. One of the physician HMO contracts we reviewed stipulates this requirement with the following clause: "Referral Physician, to the extent possible, agrees to use those inpatient, extended care, ancillary service and other health facilities and health professionals which have contracted with [HMO]." Another physician, discussing a lab he must use, says, "They get things wrong all of the time, and the contracts prohibit the physicians from telling the patients to go somewhere else to get the tests done correctly."

Clinical Independence

Other HMO restrictions also affect physicians' satisfaction with the Medicare HMO. A majority of physicians (62 percent) believe that working in a Medicare HMO at least occasionally restricts their clinical independence. Twenty-three percent say they often feel restricted, and 39 percent say they sometimes feel restricted. Additionally, half of the physicians believe working in a

Medicare HMO only sometimes (40 percent) or rarely (15 percent) allows them to practice medicine the way they think is appropriate.

Some physicians also believe that their clinical independence has been restricted by cost savings. One-quarter (27 percent) say the HMOs' costs always or frequently influence referrals for specialists or tests, 26 percent say costs always or frequently influence post-acute arrangements for their Medicare patients, and 20 percent believe costs always or frequently influence general treatment decisions. A few physicians say that over-emphasis on the Medicare HMO's profits detracts from the medical care provided to its enrollees. One respondent, expressing the views of many, says that HMOs are "businessmen practicing medicine without a license."

Many physicians also express dissatisfaction with the method or amount of their payment for their Medicare HMO patients. More than half (61 percent) are very or somewhat dissatisfied with how much they are paid by the HMO. However, fewer physicians (23 percent) say this is the factor which most influences their dissatisfaction with the Medicare HMO. Furthermore, a few say they only break even or lose money when treating Medicare HMO patients, while others mention that the HMO does not always pay them on time.

Access To Care

In assessing Medicare beneficiaries' access to care, more than one-half of physicians rate the traditional fee-for-service system higher than the HMO system. A large majority say fee-for-service is better than HMOs for access to specialists (74 percent) or for access to new treatments (69 percent). "I have to send patients out of town to see some specialists because there are not enough participating HMO physicians in town," comments one physician. Another physician says, "HMOs limit care through inconvenience." Finally, half of physicians (54 percent) say fee-for-service offers a wider range of benefits than HMOs for Medicare beneficiaries.

Physicians also cite particular problems with making referrals for their Medicare HMO patients. Twenty-nine percent of physicians think referral restrictions are worse for Medicare HMOs than for all HMOs in general, and another quarter (27 percent) say they often feel restricted in referring their Medicare HMO patients for specialists or tests. Furthermore, some of the physicians we interviewed by telephone believe the referral process is problematic for Medicare beneficiaries because they often do not fully understand the process. "The referral process," states one, "is too difficult for elderly patients."

A few physicians volunteer other problems in their HMO specific to the elderly. Several point out that due to the greater complexity of caring for Medicare patients and their comparatively poor health status, HMO treatment restrictions are particularly problematic for this population. Other physicians believe Medicare beneficiaries may not be getting the best care because they are not able to understand and work the system to their advantage.

Complaints and Appeals

Forty percent of physicians are dissatisfied with the way the HMO handles physician complaints, and 30 percent are dissatisfied with the formal appeals process. Dissatisfaction with these processes also contributes to their overall dissatisfaction. Most (63 percent) who are satisfied with the way the HMO handles physician complaints are satisfied overall, compared to just 4 percent of those dissatisfied with how complaints are handled. Finally, 50 percent who are satisfied with the appeals process but only 3 percent who are dissatisfied with that process are satisfied overall with the Medicare HMO.

Only one-quarter (28 percent) have ever formally appealed an HMO decision. Those who report their clinical independence is frequently restricted are more likely to have formally appealed an HMO decision (43 percent) compared to those who rarely feel restricted (17 percent). Furthermore, one-half of all physicians (53 percent) are generally not satisfied with how their complaints are resolved, and 16 percent say they have refrained from complaining to the HMO about something because they thought it might jeopardize their contract.

Utilization And Quality Assurance Reviews

Not all physicians believe utilization and quality assurance reviews are appropriately conducted. The HCFA has a policy that requires inclusion of a provision in HMO provider contracts that states "for services rendered to health plan members, the provider must agree to the review by the utilization management and quality assurance committees/staff." However, even though not required by regulation, less than half (40 percent) of physicians say they have ever had any kind of quality assurance review. Thirty-seven percent report never having one of these reviews and the remaining 23 percent do not know if they have had one. Of those physicians who say they have had such reviews, three-quarters (73 percent) say they were done appropriately but less than half (46 percent) say they were used appropriately.

Physicians' experiences with utilization and quality assurance reviews is related to their overall satisfaction with the Medicare HMO. One-quarter (26 percent) of physicians who believe these reviews are done appropriately are satisfied overall, compared to just 9 percent of those who do not believe the reviews are done appropriately. Similarly, 33 percent of physicians who say the reviews are used appropriately but only 7 percent who say they are used inappropriately report being satisfied overall.

Marketing Practices

A few physicians are concerned that Medicare beneficiaries are particularly susceptible to questionable HMO marketing practices. Of the fifty-five physicians who report observing fraud in a Medicare HMO, eleven report dishonest marketing practices. "HMO sales reps," writes one physician, "lie and distort to get beneficiaries to join." Another says, "The way elderly patients are treated by HMO sales reps is shameful." Seventeen of 270 physicians who volunteer suggestions to improve the Medicare HMO program recommend closer monitoring of marketing

practices. Other fraudulent practices reported by physicians but not related to marketing include delaying or denying medically necessary services and overbilling.

MOST PHYSICIANS RATE MEDICARE ENROLLEE KNOWLEDGE OF THEIR HMO LOW

A majority of physicians (at least 70 percent) believe that Medicare enrollees do not understand core elements of their HMO, as illustrated in Table C below.

Table C
Physicians' Assessment of HMO Medicare Enrollee Knowledge

Plan Elements	% that understand	% that do not understand
Appeals process	11	89
Restrictions on services	17	83
Benefits	25	75
Referral procedures	30	70

As one physician expresses, "Patients don't know exactly what they sign up for." Of the physicians who volunteer suggestions to improve the Medicare HMO program, the most frequently cited recommendation (by 19 percent of physicians) is to improve Medicare enrollee education.

Some physicians believe they cannot freely inform their Medicare patients. Fifteen percent of physicians do not feel free to discuss one or more of the following with their Medicare HMO patients: referrals for tests, referrals for specialists, referrals for non-covered services, or appeals and grievances. Most of these physicians say they feel pressure from the HMO not to discuss these issues.

DESPITE THE MISGIVINGS CITED ABOVE, MOST PHYSICIANS BELIEVE THAT THEIR MEDICARE PATIENTS RECEIVE GOOD CARE

Most Physicians Feel Positive About The Care Provided To Their Medicare Patients

Physicians' assessments of the quality of care Medicare patients receive at the HMO are generally positive. Almost three-quarters of physicians (71 percent) report that the overall quality of care Medicare enrollees get at their HMO is excellent or good. Another 21 percent rate the care as fair, while the remaining 8 percent say it is poor or very poor. Physicians' positive assessments of quality of care may appear to contradict the other concerns they have about their Medicare HMO. This may be due, in part, to their interpretation of the survey question asking them to rate the care Medicare patients get at the HMO. These physicians seem to believe they can provide good care to their patients despite some of the obstacles cited above. A few physicians say that it is the health care providers who give good care, not the HMO. Primary care physicians are more likely than specialists to rate the quality of care received by Medicare HMO patients as high; 83 percent of the former but only 63 percent of the latter say this care is excellent or good.

Similarly, most physicians (62 percent) are satisfied with their relationships with their Medicare patients. This was the most frequently cited factor by physicians (43 percent) for their overall satisfaction with the Medicare HMO. Additionally, physicians are also satisfied with the amount of time they spend with their Medicare patients. Almost all (92 percent) spend 10 minutes or more with their Medicare HMO patients for each visit. Nearly all physicians (90 percent) think this is an adequate amount of time.

Physicians volunteer various suggestions for improving the care provided to Medicare patients in HMOs. These include improving the referral process, giving physicians greater medical autonomy, monitoring access to treatment, and giving Medicare patients greater provider choice.

HMO Referral Times and Medicare Enrollee Knowledge Are Linked To Quality Of Care

The length of the referral process is linked to physicians' perceptions of quality of care. Ninety-four percent of physicians whose staff gets through right away when calling the HMO for pre-certification rate their patients' care as good, compared to only 62 percent of those whose staff takes more than 30 minutes to reach the HMO. Furthermore, one third of the physicians (36 percent) whose HMO takes more than 7 days to reach a decision report that their patients' quality of care is poor or very poor, compared to only 3 percent of physicians whose HMO reaches that decision within 1 hour.

Physician perceptions of Medicare enrollee knowledge are also linked to their perceptions of quality of care. Eighty-six percent of physicians who believe their patients understand HMO service restrictions feel that overall quality of care in the Medicare HMO is good. Conversely, just 67 percent of physicians who do not believe their patients understand HMO restrictions on services believe quality of care is good. Similarly, a majority of physicians who believe

beneficiaries understand referrals, benefits, and appeals think quality of care in the HMO is good (81, 87, and 87 percent respectively), compared to fewer of those who do not believe their patients understand these aspects of the HMO (65, 65, and 68 percent respectively).

CONCLUSION

Needless to say, HCFA should work with physicians to address their concerns about Medicare HMOs and to improve the quality of services provided to Medicare HMO enrollees. We believe that greater physician satisfaction with the Medicare HMO program will enhance both enrollees' and providers' experiences with that program.

This survey identifies the issues which most concern Medicare HMO physicians, many of which are general in nature, such as a lack of clinical independence and restrictions on access to care. Such concerns are most likely to be resolved through overall improvement of the HMO program.

However, there are other distinct concerns we believe might be more amenable to specific solutions. In particular, physicians expressed the following concerns:

- the appeals process
- beneficiary knowledge
- the referral process
- utilization and quality assurance reviews

We believe that the implementation of the 1997 Balanced Budget Act "MedicarePlus" program provides HCFA with an opportunity to address physicians' concerns about the lack of beneficiary HMO knowledge. This program gives beneficiaries the option of receiving their Medicare benefits through MedicarePlus plans, which would include HMOs and other coordinated plans such as Preferred Provider Organizations (PPOs). These plans will be required to provide specific information to beneficiaries at enrollment, and annually thereafter, about certain plan features such as quality of care, utilization reviews, and procedures for appeals and grievances.

Other approaches HCFA may want to consider in addressing these issues include establishing HMO performance standards, such as for referral times and utilization and quality assurance reviews. It may be necessary to conduct further studies of specific areas of concern. Whatever approach is used, we believe a process of consultation between HCFA and physician groups would be a good first step towards resolving some of their concerns.

The OIG plans to periodically repeat this physician survey to determine if progress is being made in improving physician satisfaction. We also plan to continue our surveys of Medicare beneficiaries to obtain their experiences and satisfaction with their HMOs.

COMMENTS

We received comments on the draft report from HCFA. They concur with our general observations and conclusion and state that the Balanced Budget Act of 1997 addresses many of the physicians' concerns reported in our study. Both the Assistant Secretary for Management

and Budget (ASMB) and HCFA provided technical comments, which have been incorporated into the final report when appropriate.

The HCFA suggests that we remove a reference in our conclusion to prior OIG recommendations on strengthening the appeals and grievance procedures for beneficiaries. We agree with their suggestion and have removed this reference from our report.

The HCFA also notes that our report does not indicate whether physician experience with Medicare HMOs differs from their experience with non-Medicare HMOs and suggests that it would be helpful to conduct a comparable survey of physicians about the Medicare fee-for-service system. We agree that it would be useful to study these comparisons; however, such analysis was not within the scope of our work.

The full comments from HCFA are presented in Appendix F.

APPENDIX A

SAMPLE SELECTION

The universe for this inspection consisted of all physicians in HCFA's Unique Physician Identification Number (UPIN) database, excluding pediatricians, residents, interns, and non-medical doctors, as well as physicians in States without Medicare HMOs (Maine, Mississippi, Montana, New Hampshire, South Dakota, and Wyoming).

Because HCFA can not identify physicians with Medicare HMO contracts, we had to conduct a test. A pre-inspection probe sample indicated that approximately 30 percent of physicians in the UPIN database have one or more contracts with Medicare HMOs. To increase the probability of sampling these physicians, we grouped the physicians into two strata. The high Medicare HMO enrollment stratum consisted of physicians who practice in the 13 States with the highest percentage of Medicare HMO enrollees, and the low stratum consisted of physicians in the remaining States. For the 5 percent of physicians with business addresses in both strata, we randomly selected one address per physician and used it for stratum assignment.

We determined that a sample size of 2,500 physicians was necessary to assure statistically valid conclusions, with a 95 percent confidence level and 5 percent precision level. We based this sample size on our estimation of the percentage of physicians with Medicare HMO contracts and on the assumption of a 40 percent response rate. We then randomly selected 1,500 physicians from the high stratum and 1,000 from the low stratum as follows:

Strata	Universe	Sample
High Medicare HMO enrollment	248,355	1500
Low Medicare HMO enrollment	227,855	1000
TOTAL	476,210	2,500

We weighted the collected data by stratum, using the following formula:

$$WT = \frac{\text{Universe of physicians in stratum}}{\text{Sampled physicians in stratum}}$$

APPENDIX B

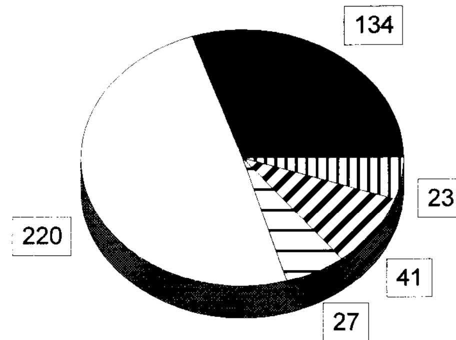
PROFILE OF MEDICARE HMO PHYSICIANS

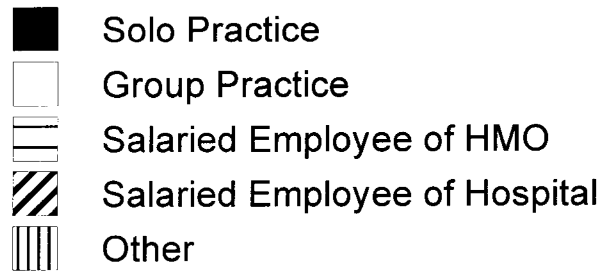
I. A variety of physicians appear to be contracting with Medicare HMOs as shown in the following tables and charts.

Table B-1
Responding Physician By Primary Specialty

Primary Specialty (UPIN Code)	Responding Physicians
01 General Practitioner	4%
02 General Surgery	6%
05 Anesthesiology	3%
06 Cardiology	4%
07 Dermatology	3%
08 Family Practice	14%
10 Gastroenterology	3%
11 Internal Medicine	20%
13 Neurology	3%
16 Obstetrics/Gynecology	5%
18 Ophthalmology	4%
20 Orthopedic Surgery	3%
26 Psychiatry	5%
29 Pulmonary Disease	2%
30 Diagnostic Radiology	3%
34 Urology	3%
83 Hematology/Oncology	2%
93 Emergency Medicine	2%
Other	11%
TOTAL	100%

Chart B-1
Responding Physician By Type Of Practice





* Four physicians did not indicate type of practice

Table B-2
Responding Physicians By Age

Minimum Age	28
Maximum Age	77
Mean Age	48

II. In our telephone interviews, we asked 25 physicians why they chose to contract with a Medicare HMO. Table B-3 shows the reasons they give.

Table B-3
Physicians' Reasons For Contracting With Medicare HMO

Reason	Physicians
Preserve relations with long-time Medicare patients	9
Economic survival	9
Attractive HMO market	6
HMO or Group decided	6
Like HMOs	3

APPENDIX C

NON-RESPONDENT ANALYSIS

When questionnaires are used to collect data, the results may be biased if non-respondents differ from respondents. For this inspection, a physician for whom a questionnaire was not received is a non-respondent. To test for the presence of any bias, we first obtained information from HCFA's Unique Provider Identification Number file for all 2,500 physicians who were sent a mail questionnaire. A total of 1,140 questionnaires were returned, for an overall response rate of 45.6 percent. The following table illustrates the number of responses and the response rate by strata:

STRATA	Number	Response Rate
High Medicare HMO enrollment States	678	45%
Low Medicare HMO enrollment States	462	46%
Total Respondents	1140	46%

To test for the presence of any non-response bias, we analyzed the variables that might influence whether an individual would respond to the survey or that might affect his or her responses. For the 2,500 physicians in our sample, we looked at medical specialty, type of practice, and strata. These categorical variables were tested using Chi-square with the appropriate degrees of freedom. In order for the results to be statistically significant at the 95 percent confidence level, the chi-square value must be higher than 3.84 with 1 degree of freedom.

The results of this analysis are presented in tables C-1, C-2, and C-3. The Chi-square values given in the tables provide a test of the difference between the distribution of the respondents and that of the non-respondents for the variable of interest. Also provided in the tables are the response rates by the different values of the variables.

Table C-1

Medical Specialty						
	Respondents		**Non-respondents**		**Total**	**Response Rate**
Primary Care*	392	34%	482	35%	874	45%
Specialist	748	66%	878	65%	1626	46%
Total	**1140**		**1360**		**2500**	**46%**

CHI-SQ = .304
Degrees of Freedom = 1
* As classified in the UPIN file

Table C-2

Type of Practice						
	Respondents		**Non-respondents**		**Total**	**Response Rate**
Group	526	46%	709	52%	1235	43%
Solo	614	54%	649	48%	1263	49%
Total	**1140**		**1358***		**2498***	**46%**

CHI-SQ = 9.131
Degrees of Freedom = 1
* No data available for 2 physicians

Table C-3

Strata (Extent of Medicare HMO Enrollment in State)						
	Respondents		Non-respondents		Total	Response Rate
High	678	59%	822	60%	1500	45%
Low	462	41%	538	40%	1000	46%
Total	**1140**		**1360**		**2500**	**46%**

CHI-SQ = .242
Degrees of Freedom = 1

Tables C-1 and C-3 show no statistically significant differences between respondents and non-respondents for medical specialty and extent of Medicare HMO enrollment in State.

Table C-2 shows a statistically significant difference between respondents and non-respondents with respect to type of practice (group vs. solo). In order to test whether this difference introduced any bias, we analyzed the rates of overall dissatisfaction with Medicare HMOs, for differences between group and solo physicians.

The proportion of physicians dissatisfied with Medicare HMOs differed by 10 percentage points between types of practice, so further analysis was required. Assuming that non-respondents and respondents from the same type of practice had the same level of dissatisfaction, we calculated a hypothetical global dissatisfaction rate for all 2,500 physicians in the sample. This calculation gave only a slightly lower dissatisfaction rate of 42 percent (compared to 43 percent for respondents). This difference is not statistically significant.

Given the results of this analysis, we believe that the inspection findings fairly represent the experience and opinions of physicians to whom the questionnaires were sent.

APPENDIX D

CONFIDENCE INTERVALS FOR KEY SURVEY QUESTIONS

We calculated confidence intervals for 16 key questions from the physician mail survey. The response estimate and 95 percent interval are given for each of the following:

1. What is your overall satisfaction with the Medicare HMO?
   "Very or somewhat dissatisfied" response estimate: 43%
   Lower interval: 38%
   Upper interval: 48%

2. Generally, how long does it take for you or your staff to speak to an HMO representative when calling for approval of referrals for specialists or tests?
   "More than 1/2 hour" response estimate: 30%
   Lower interval: 25%
   Upper interval: 35%

3. Generally, how long does it take the HMO to approve or deny referrals?
   "3 or more days" response estimate: 28%
   Lower interval: 23%
   Upper interval: 33%

4. Generally, how would you rate the overall quality of care Medicare enrollees get at your HMO?
   "Excellent or good" response estimate: 71%
   Lower interval: 67%
   Upper interval: 75%

5. Do you think your Medicare patients generally understand the HMO's procedures for referral?
   "No" response estimate: 70%
   Lower interval: 66%
   Upper interval: 74%

6. Do you think your Medicare patients generally understand the HMO's restrictions on services?
   "No" response estimate: 83%
   Lower interval: 80%
   Upper interval: 86%

7. Do you think your Medicare patients generally understand their HMO benefits?
"No" response estimate: 75%
Lower interval: 71%
Upper interval: 79%

8. Do you think your Medicare patients generally understand the HMO's appeals and grievance process?
"No" response estimate: 89%
Lower interval: 86%
Upper interval: 92%

9. Overall, how satisfied are you with the Medicare HMO referral process?
"Very or somewhat dissatisfied" response estimate: 42%
Lower interval: 37%
Upper interval: 47%

10. Overall, how satisfied are you with the way the Medicare HMO handles physician complaints?
"Very or somewhat dissatisfied" response estimate: 40%
Lower interval: 35%
Upper interval: 45%

11. Overall, how satisfied are you with the formal appeals process?
"Very or somewhat dissatisfied" response estimate: 31%
Lower interval: 26%
Upper interval: 36%

12. Do HMOs or FFS provide better access to new treatments for Medicare patients?
"FFS is better" response estimate: 69%
Lower interval: 65%
Upper interval: 73%

13. Do HMOs or FFS provide better access to specialists for Medicare patients?
"FFS is better" response estimate: 74%
Lower interval: 70%
Upper interval: 78%

14. Has working for a Medicare HMO restricted your clinical independence?
"Often or sometimes" response estimate: 62%
Lower interval: 57%
Upper interval: 67%

15. Do Medicare HMOs allow you to practice medicine the way you think is appropriate?
"Sometimes or rarely" response estimate: 55%
Lower interval: 50%
Upper interval: 60%

16. Do you feel restricted in referring Medicare HMO patients for specialists or tests?
"Often" response estimate: 27%
Lower interval: 23%
Upper interval: 31%

APPENDIX E

STATISTICAL TESTS FOR KEY FINDINGS

We computed chi-square values for differences in physicians' overall satisfaction for six variables. In order for the results to be statistically significant at the 95 percent confidence level, the chi-square value must be higher than 3.84 with 1 degree of freedom. As shown in the tables below, each chi-square test exceeded this requirement. The direction of the differences noted below are discussed in the findings of this report.

Table E-1
Chi-Square Values for Testing Significance of Differences in Satisfaction

Variable	DF*	Chi-Square
Type of Practice (Salaried HMO employee vs. other)	1	10.02
Specialists vs. Primary Care	1	14.88
Satisfaction with Referral Process	1	79.92
Satisfaction with Complaint Process	1	55.99
Satisfaction with Appeals Process	1	27.26
Quality of Care Rating	1	53.34
Rating of appropriate conduct of utilization and quality assurance reviews	1	5.38
Rating of appropriate use of utilization and quality assurance reviews	1	9.17

* Degrees of Freedom

We also computed chi-square values for differences in physicians' ratings for quality of care for four variables. Chi-square values show that differences on all four variables were significant at the 95 percent confidence level.

Table E-2
Chi-Square Values for Testing Significance of Differences in Quality of Care Ratings

Variable	DF*	Chi-Square
Beneficiary understanding of HMO procedures for referral	1	11.60
Beneficiary understanding of restrictions on services	1	14.27
Beneficiary understanding of benefits with HMO	1	25.70
Beneficiary understanding of HMO appeals and grievance process	1	10.11

* Degrees of Freedom

APPENDIX F

In this appendix, we present in full the comments from the Health Care Financing Administration.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

IG ✓
EAIG
SAIG ✓
PDIG
DIG-AS
DIG-EC ✓
DIG-EI
DIG-OI
DIG-MP
AIG-LC
OGC/IG ✓
ExecSec
Date Sent 4-7

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GENERAL

DATE: APR - 1 1998

TO: June Gibbs Brown
Inspector General

FROM: Administrator
Health Care Financing Administration

SUBJECT: Office of Inspector General (OIG) Draft Report: "Physician Perspectives of Medicare Health Maintenance Organizations (HMOs)," (OEI-02-97-00070)

We reviewed the above-referenced report that examines the experiences and perspectives of physicians who work with Medicare HMOs. The report found that: (1) overall physician satisfaction with Medicare HMOs is low; and (2) most physicians rate Medicare enrollees' knowledge of their HMO low.

The report concludes that the Health Care Financing Administration (HCFA) should work with physicians to address their concerns about Medicare HMOs and improve the quality of services provided to Medicare enrollees.

We agree that we should work with physicians to address concerns about Medicare HMOs, and are already doing so. The Balanced Budget Act of 1997 (BBA) will allow us to address many of the physicians' concerns. However, while the OIG report is interesting and useful, it is important to note that it does not indicate whether physician experience with Medicare HMOs differs from their experience with non-Medicare HMOs. Our detailed comments follow:

OIG Recommendation #1

HCFA should monitor HMOs to ensure beneficiaries are issued written determinations, including appeals rights.

HCFA Response

We concur. Medicare is already in compliance with the President's Consumer Bill of Rights and Responsibilities provisions on appeals, and provides its beneficiaries with stronger appeal rights than those that exist in the private sector.

HCFA is currently revising the Contractor Performance Monitoring Reviewer's Guide which is used to review health plans and ensure compliance with written determinations and appeals rights. The guide has been updated to include model language.

Our Quality Improvement System for Managed Care (QISMC) also includes clear standards on how managed care plans should inform beneficiaries on procedures and time limits for resolving appeals, complaints, grievances, and other issues. We plan to review these standards on an annual basis at Medicare HMOs.

OIG Recommendation #2
HCFA should work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment procedures and operating procedures.

HCFA Response
We concur, and have already drafted model appeal language to be used in marketing materials, denial notices, and notices of non-coverage. This model language was sent to all Medicare managed care plans in July, 1997. QISMC, which also features model language designed so standards can be applied fairly, objectively, and uniformly, will allow us to work with managed care plans to establish these standards in their procedures.

OIG Recommendation #3
Implement the BBA "MedicarePlus" program which provides HCFA with an opportunity to address physicians' concerns about the lack of beneficiary knowledge.

HCFA Response
We concur, and are currently drafting a regulation that will address many of these concerns.

OIG Recommendation #4
HCFA may want to consider establishing HMO performance standards, such as for referral times, and utilization and quality assurance reviews.

HCFA Response
We concur. We are planning to incorporate performance standards addressing additional HMO requirements for referral times, utilization, and quality assurance reviews in the BBA regulations. These standards will be reviewed for compliance by HMOs on an annual basis.

Technical Comments
Page 7, Referral Process - Waiting times of 3 days or less may not be unreasonable since these are not emergency situations. Physicians concerned about poor quality providers should document and submit complaints to the appropriate HMO, since physician feedback is essential for HMOs to maintain the integrity of their delivery networks.

Physicians are justified in complaining about the number of different authorization and referral procedures of numerous HMOs. However, it is generally the staff in physician offices who must use these procedures, and HCFA compliance reviews ensure that Medicare contracting companies supply their physicians with provider manuals. These manuals not only explain referral and authorization procedures, but also explain how to file complaints with the HMO. The OIG survey stated that three interviewed physicians complained about poor quality providers. We hope these physicians also submitted their documented complaints to the appropriate HMO.

Page 10, Utilization and Quality Assurance Reviews - There is an incorrect statement that "Regulations require Medicare HMOs to provide for such reviews in their provider contracts." HCFA has a policy rather than a regulatory requirement that requires inclusion of a provision in HMO contracts with providers which states, "For services rendered to health plan members, the provider must agree to the review by the utilization management and quality assurance committees/staff." The review specified is not required to be a review of an individual provider's operations, but is typically a review of aggregated data or procedures relating to a specific study area. Consequently, "having one of these reviews" is not a relevant concept and is not required by regulation or statute. There is no "specified review," but there is a general agreement to permit review of all clinical behavior.

Page 10, Marketing Practices - There is a sentence relating to other fraudulent practices. It is unclear how "delaying or denying medically necessary services and over billing" relates to marketing practices. Also, it is unclear who is engaging in these actions.

Conclusion Section - The information presented relating to appeals is confusing. Based on the survey, physicians were asked if they were satisfied with the formal appeals process. We assume that this relates to: (1) the process that a physician would use to appeal an HMO denial of a referral or prior authorization request; and (2) the study results as presented on pages 9 and 10. However, the recommendations also include prior OIG report recommendations relating to beneficiary appeal rights. OIG should clarify whether it is recommending that HCFA implement physician appeal rights or beneficiary appeal rights. It should be noted that physician appeal procedures are generally found in the HMO provider manuals, and on July 22, 1997, HCFA advised HMOs of new and expedited appeals procedures for beneficiaries, as published in regulation.

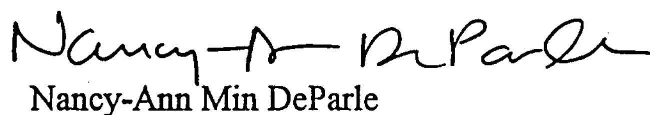
Did the OIG survey ask the dissatisfied-physicians, what steps, if any, they had taken to convey their dissatisfaction to the plans and what each plan's response was?

Has the OIG ever done comparable surveys for original fee-for-service Medicare? If so, it would be helpful to have the comparisons.

It would be useful to know if the concerns about referrals relate to difficulties obtaining plan authorization to make referrals, or to inadequate capitation payments for physicians to pay for referral services.

It is unclear if some concerns related to beneficiaries are unique to HMOs or may also be the case for beneficiaries in fee-for-service Medicare. For example, how well do fee-for-service beneficiaries understand their Medicare benefits? (We recognize that it is more important for HMO enrollees to understand these matters, given financial incentives for HMO providers to render fewer services than fee-for-service providers.)

With respect to questionable HMO practices in enrolling Medicare beneficiaries, we note that the Administration sought authority during the BBA deliberations to have all enrollment handled by a neutral third party, but the Congress did not include this provision in the BBA. The Congress did, however, mandate a demonstration of the use of third-party contractors to conduct enrollment and disenrollment under the Medicare+Choice program.



Nancy-Ann Min DeParle