Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Physician Incentive Plan Reporting for Medicare + Choice Organizations

JANET REHNQUIST
Inspector General

April 2002
OEI-05-00-00010

OFFICE OF INSPECTOR GENERAL

http://www.oig.hhs.gov/

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EXECUTIVE SUMMARY

PURPOSE

To assess Physician Incentive Plan (PIP) reporting by Medicare + Choice organizations.

BACKGROUND

The managed care organizations' use of physician incentives raised public and Congressional concerns about the potential for underutilizing appropriate medical services and discouraging needed hospitalizations and referrals to specialists. In response, Congress banned Medicare + Choice managed care organizations from linking physician incentives to reducing or limiting necessary medical services to specific Medicare patients in managed care programs. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), issued regulations on physician incentives in 1996. Under these regulations, Medicare + Choice managed care organizations can make no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee and must provide stop-loss coverage for providers who face substantial financial risk in treating Medicare beneficiaries. In 1997, CMS required that each Medicare + Choice managed care organization annually report all contractual arrangements with physicians, provider groups and intermediate entities in order to determine compliance with the regulations.

FINDINGS

The CMS physician incentive information collected from managed care organizations focuses on financial risk and stop-loss coverage for providers

By design, the data CMS collects is limited to determining the adequacy of stop-loss coverage for providers. The physician incentive plan law requires that physicians who might be at substantial financial risk in treating beneficiaries have appropriate stop-loss coverage. The CMS characterizes Medicare + Choice managed care organization incentive arrangements as either compliant or non-compliant with reporting regulations based on a formula using the amount of stop-loss coverage and the number of Medicare beneficiaries they treat, called patient panel size. The current process is not designed to detect whether needed services are being restricted or otherwise affecting the access to medically necessary services.

The information is incomplete, unreliable, and inconsistent

The physician incentive data CMS does collect is incomplete, inaccurate, and inconsistent. Some managed care organizations do not report all of their contracting arrangements. Few managed care organizations routinely verify the information that downstream providers give them for physician incentive plan reporting. Likewise, CMS does not routinely verify the data managed care organizations submit. The CMS regional offices do not have access to and do not review any intermediate entity subcontracts during their biennial Medicare + Choice onsite reviews.

Medicare + Choice managed care organizations and their providers report that the physician incentive plan reporting process is burdensome and costly

Many Medicare + Choice managed care organizations and their providers expend considerable time and financial resources in annually reporting physician incentive plan data to CMS. Managed care organizations with 22 Medicare + Choice contracts reported that their direct physician incentive plan reporting expenses averaged nearly $25,000 in 2001.

Both CMS and managed care organizations already collect information which could help determine if incentive arrangement problems exist

Managed care organizations collect information that measures consumer satisfaction, access to care, and quality of care. They also have information about incentives with providers relating to utilization and quality targets. While CMS is not required to collect this data, it would assist CMS regional office staff in meeting the requirements in the onsite managed care monitoring guide relating to quality, access and utilization. The CMS is currently developing a data-driven system that will provide a more comprehensive view of managed care organizations' activities, including physician incentives.

RECOMMENDATION

The CMS should replace the current reporting system with other approaches that are more effective and less burdensome

The CMS should terminate the current reporting process which represents a considerable expense of funds, staff, and computer time for Medicare + Choice managed care organizations. Eliminating this process would greatly reduce the reporting burdens for managed care organizations and their physicians. Instead of the current annual managed care organization reporting of stop-loss coverage, CMS could:

- require attestations regarding physician payment incentives in all managed care organizations and downstream provider contracts;
- require appropriate stop-loss coverage for all managed care organizations, including downstream providers where incentives are involved;
- periodically verify, during onsite reviews, the accuracy of attestations and presence of stop-loss coverage and ensure that managed care organization incentives tied to financial goals do not violate the law; and,
- identify data already collected that may suggest if health care quality and utilization are affected by physician payment incentives.

AGENCY COMMENTS

We received comments on this report from CMS. They concur with our recommendation and are modifying the PIP regulations to reduce administrative burden on Medicare + Choice managed care organizations. The CMS is also continuing to implement quality improvement assessments that more directly measure health care quality and access in a managed care setting. Their comments can be found in Appendix D. Additionally, technical comments were provided by CMS and were incorporated where appropriate.

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INTRODUCTION

PURPOSE

To assess Physician Incentive Plan (PIP) reporting by Medicare + Choice organizations.

BACKGROUND

Medicare Managed Care

The Balanced Budget Act of 1997 established the Medicare + Choice program which expanded the types of managed care entities that could contract with the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), to provide health care services to Medicare beneficiaries. All health plans participating in the Medicare + Choice program receive a monthly per capita reimbursement and are responsible for providing all necessary services to enrollees. The CMS requires all Medicare + Choice managed care organizations to provide access to a sufficient number of providers, including physicians, to ensure beneficiaries have adequate access and continuity of care. The managed care organizations decide whether to hire salaried providers or contract for providers' services using fee-for-service, capitation, or other reimbursement methods. If a managed care organization pays fee-for-service to providers, the providers themselves face no financial risk in treating beneficiaries, and there is no financial incentive for providers to withhold any medical services to individuals or restrict referrals to non-managed care organizations' providers for out-of-plan treatment. However, under other arrangements, providers may be at financial risk depending on the terms of their contracts. (Appendix A contains a glossary of managed care terms used in this report.)

Risk Transfer

Managed care organizations transfer financial risk to providers through certain contractual arrangements. Common types of risk transfer arrangements include capitation, percent of premium, withholds, and bonuses. Capitation is a set dollar payment per patient per unit of time (usually monthly) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. A percent of premium is a predetermined percentage of overall revenue from beneficiary premiums. A withhold is a percentage of payment or set dollar amount that managed care organizations deduct from a provider's payment, and that may or may not be returned, depending on whether specific predetermined factors are met. Similarly, a bonus is a payment a provider receives beyond any salary, fee-for-service payments, capitation or returned withhold, depending on whether specific predetermined factors are met. Any of these incentives may be used to encourage

compliance with hospital or pharmacy utilization targets, or tied to results on various measures from patient satisfaction surveys.

If a provider assumes global risk for treating patients, the provider is financially responsible for the costs of all the medical services, including hospitalization and pharmacy, that those patients incur. The CMS considers providers to be at substantial financial risk when 25 percent or more of their potential managed care organization reimbursement depends on referrals they make or services they provide. When this substantial financial risk threshold is reached, Medicare + Choice managed care organizations must ensure that providers have insurance (called stop-loss) that protects providers from serious financial consequences for treating Medicare beneficiaries. Providers with more than 25,000 patients are exempted from the stop-loss coverage requirements, because it is assumed that any risk would be spread throughout this large patient population.

Physician Incentive Plans

Many managed care organization contracts with physicians and other providers contain provisions for transferring risk. These provisions contain financial or other incentives intended to influence the practice styles of physicians to achieve specific outcomes or reduce the health plan's costs. Incentives may be included in direct contracts between managed care organizations and physicians or provider groups as well as any subcontracts between these entities (called downstream providers).

Law Prohibits Use of Certain Physician Incentive Plan Arrangements

The managed care organization use of physician incentives raised public and congressional concerns about the potential for underutilizing appropriate medical services and discouraging necessary hospitalizations and referrals to specialists. In response to these concerns, Congress banned Medicare + Choice managed care organizations from linking physician incentives to reducing or limiting necessary medical services to specific Medicare managed care patients.[1]

Section 1876 of the Social Security Act prohibits managed care organizations from entering into compensation arrangements with physicians or physician groups that may directly or indirectly have an effect of reducing or limiting services to individual enrollees. The managed care organizations may, however, operate physician incentive plans if they meet the following requirements:

- No specific payment is made, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee.

[1] Public Law 99-509, Omnibus Budget Reconciliation Act of 1986, Section 9313(c)

- If a physician or physician group is placed at substantial financial risk for referrals, the managed care organization ensures that stop-loss coverage is provided and conducts periodic surveys of enrollees and disenrollees.
- The managed care organization must provide CMS with descriptive information sufficient to determine compliance with these requirements.

Regulations Implementing Physician Incentive Plan Law

The CMS informed managed care organizations that the purpose of the final rule implementing the physician incentive plan law is to provide adequate protection to beneficiaries so they have access to necessary and appropriate care. To implement this law and its subsequent changes, CMS issued several regulations, culminating with major revisions effective in 1996.[2]

Under the 1996 regulations, CMS allows Medicare + Choice managed care organizations to use physician incentives in their contractual arrangements with Medicare providers if certain conditions are met. The managed care organizations:

- cannot curtail access to necessary medical services,
- must provide stop-loss coverage for managed care organization providers who face substantial financial risk,
- must conduct surveys of beneficiaries and disenrollees when providers are at substantial financial risk, and,
- must generally disclose incentive arrangements to Medicare beneficiaries.

Any Medicare + Choice managed care organization violating this regulation faces civil monetary penalties up to $25,000 for each infraction, as well as possible program sanctions.

Physician Incentive Plan Requirements

Beginning in 1997, CMS required Medicare + Choice managed care organizations to annually report all contractual arrangements involving incentives with physicians and provider groups in order to determine compliance with physician incentive plan regulations. The regulations specify the kind of information the managed care organizations must report to CMS. The managed care organizations must report:

- whether referrals made by the physician or physician group are covered in the incentive plan;
- the type of incentive arrangement or the method used to transfer risk (e.g., withhold, bonus, capitation);

[2] 42 CFR 422.208, 42 CFR 422.210

- the percent of the withhold or bonus the plan uses (used to determine whether physician or group is at substantial financial risk);
- assurance that the physician or group has adequate stop-loss coverage;
- the patient panel size and pooling method used, if any (also used to determine whether a physician or group is at substantial financial risk); and,
- if the managed care organization is required to conduct an enrollee/disenrollee survey.

These requirements apply to managed care organization direct and indirect contracting arrangements with physicians, provider groups, and intermediate entities. In 1999, managed care organizations representing 352 Medicare + Choice contracts reported over 8,000 incentive arrangements with physicians and providers. Less than half of these arrangements transferred any risk to providers.

Onsite Review of Physician Incentive Plans and Access to Care

Another method CMS uses to collect information about physician incentive plan compliance is the biennial onsite review of managed care organizations. The CMS regional offices use a structured series of general questions on physician incentives when conducting the biennial onsite managed care organization reviews. These questions focus on physician incentive plan reporting elements and contract language. The CMS regional offices use a structured guide to determine whether managed care organizations meet the required reporting and beneficiary disclosure rules.

In addition, CMS instructs its regional offices to review physician incentive plans in their analysis of access and availability of care for Medicare beneficiaries. They also examine other quality measures in conjunction with physician incentive plans to determine whether underutilization of services may be occurring.

SCOPE AND METHODOLOGY

We used four methods of data collection in this evaluation. We examined physician incentive plan data submitted to CMS by managed care organizations, sent a fax survey to Medicare + Choice managed care organizations, conducted personal or telephone interviews with staff from CMS headquarters and regional offices, and conducted site visits of a purposive sample of managed care organizations.

First, we examined the 1999 data that managed care organizations provided to CMS to describe the physician incentive plan landscape and to identify the existence of any significant patterns in annual physician incentive plan reporting.

Second, we sent a fax questionnaire to Medicare + Choice plans, representing 252 managed care organization contracts. We excluded Medicare + Choice demonstration

contracts and cost contracts and focused on managed care organization risk plans. The questionnaire contained a mix of open and closed-ended questions regarding the types of physician incentive plan information collected, how accuracy of data is assured, what elements of physician incentive plan arrangements are not reported, what non-contractual methods are used for arranging incentives, and the presence of incentive arrangements with non-primary care staff. We did not request details regarding specific dollar amounts of potential incentives. We received 227 of the 252 surveys, a response rate of 90 percent.

Third, we conducted personal or telephone interviews with staff from CMS headquarters and regional offices responsible for monitoring physician incentive plan information. We used a structured format of both open and closed-ended questions to elicit information about the physician incentive plan data collection process. We asked specific questions about the nature and the detail of physician incentive data they collect and review during the biennial onsite managed care organization reviews. We asked CMS staff about the roles the regional offices play in collecting physician incentive plan data, how they use the physician incentive plan data, and what types of feedback they give to managed care organizations. We gathered information to determine whether adequate mechanisms exist to report questionable incentive arrangements and what actions are taken in those situations. We also asked CMS staff for suggestions about data that could be collected in addition to, or instead of, what is currently being collected to monitor physician incentive plans. We reviewed the monitoring guides CMS offices use in conducting their biennial onsite reviews of Medicare + Choice plans.

Finally, to collect more in-depth information, we conducted onsite visits and performed follow-up interviews to a purposive sample of 38 managed care organizations in 9 metropolitan areas. The metropolitan areas selected represent a diverse cross-section of annual physician incentive plan reporting characteristics. We visited a mix of managed care organizations in these metropolitan areas that CMS determined to be either compliant or non-compliant in their stop-loss arrangements. We visited 38
Medicare + Choice managed care organizations located in Denver, Dallas, Detroit/Ann Arbor, Miami/Ft. Lauderdale, Hartford/New Haven, Los Angeles, San Francisco, Oklahoma City/Tulsa, and Seattle. We conducted all onsite visits in June and July 2000.

During these onsite visits with the managed care organizations, we used a structured discussion guide containing open-ended questions to gather in-depth information about the managed care organizations, the local managed care environment, history of incentive use, and annual physician incentive plan reporting and oversight.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

The CMS physician incentive information collected from managed care organizations focuses on financial risk and stop-loss coverage for providers

The physician incentive plan law requires that physicians who might be at substantial financial risk in treating beneficiaries have appropriate stop-loss coverage. The CMS requires Medicare + Choice managed care organizations to report whether they transfer risk to providers. Of 8,651 incentive arrangements reported to CMS by managed care organizations in 1999, 3,306 contracts transferred risk globally (for all medical services delivered) to providers, provider groups, and intermediate entities, and 2,229 contracts transferred risk specifically for referrals. The managed care organizations also report the type of incentive arrangements they have, but do not provide any details of specific proprietary financial arrangements they have with providers.

The CMS characterizes Medicare + Choice managed care organization incentive arrangements as either compliant or non-compliant with reporting regulations based on a formula using the amount of stop-loss coverage and the number of Medicare beneficiaries they treat, called patient panel size. In 1999, CMS determined that 193 (5 percent) out of 3,606 Medicare + Choice arrangements where risk transfer was reported were non-compliant due to inadequate stop-loss coverage. If an arrangement is non-compliant, CMS enters this information into the physician incentive plan database and sends a notice to the managed care organization informing them of the decision. The CMS does not routinely require managed care organizations to take corrective action on these non-compliant arrangements. The CMS acknowledges conducting minimal compliance activities in 1999 due to efforts to implement the new electronic PIP data submission system.

The CMS provides little feedback to managed care organizations on their physician incentive plan submissions. Only 26 percent (59 of 227) of managed care organizations responding to our survey report having any CMS review of the physician incentive plan data they submitted. Most of these managed care organizations report that CMS regional offices' review occurred during their biennial monitoring process. During our interviews with CMS regional staff, we learned that the degree of oversight of physician incentive plans varies among offices. Two regional offices reported that they did not review the physician incentive plan disclosure during the last biennial monitoring review (one regional office was receiving training at the time of our review). The remainder of the regional offices reported that they reviewed some physician incentive plan data during their most recent biennial review. Several CMS regional staff volunteered that the type of incentive information collected from Medicare + Choice plans is not useful to them in conducting their onsite reviews. The current process is not designed to

detect whether needed services are being restricted or otherwise affecting the access to medically necessary services.

The information is incomplete, unreliable, and inconsistent

During our onsite visits, managed care organization representatives reported various problems relating to the completion of the annual physician incentive plan disclosure. Although CMS requires disclosure even if incentive arrangements do not exist, three managed care organizations we spoke with report only those arrangements where incentives are involved.

Some managed care organizations report that they have the contracted physicians, groups and other entities complete the physician incentive plan reporting, and these providers do not always understand the terms and definitions used by CMS or the importance of the data. Three managed care organizations told us that some of the terms used in the physician incentive plan disclosure form are confusing and need to be better defined. Most Medicare + Choice plans that contract with intermediate entities (111 of 169 contracts) accept the information that downstream providers gave them for physician incentive plan reporting. A few managed care organizations indicated they would call the downstream provider if a number reported looked questionable.

The CMS only requires intermediate entities to report incentives if they are contained in subcontracting arrangements with physicians or physician groups. Some managed care organizations do not report the details of arrangements intermediate entities have with their subcontracted providers. One managed care organization said they do not report beyond the first tier or the direct contract with the managed care organization. Another said they believed there was a three-tier (contract, subcontract, sub-subcontract) limit in applying the physician incentive plan requirements. Downstream providers may further subcontract with other providers. Another managed care organization said they do not collect incentive data if providers are employed by a provider group or intermediate entity. In this case, the managed care organization does not consider the providers to be downstream providers since the contracting entity employs them. The CMS does not know how many providers in downstream contracts with intermediate entities are involved in treating Medicare + Choice beneficiaries. The CMS regional offices do not have access to and do not review any intermediate entity subcontracts during their biennial Medicare + Choice onsite reviews.

As a result, CMS (or in many cases, the contracting managed care organization) does not know whether the downstream contracts contain incentives that violate the law. In our fax survey, we found that only 31 of 166 Medicare + Choice contracts have language in their contracts with intermediate entities that details what incentives the law prohibits.

We found that managed care organizations frequently offer incentives to intermediate entities, most often for meeting targeted financial goals (78 of 169 managed care

organizations contracts with intermediate entities, or 46 percent). The incentives in managed care organization contracts with intermediate entities refer only to those entities and not to contracts they have with downstream providers.

Medicare + Choice managed care organizations and their providers report that the physician incentive plan reporting process is burdensome and costly

Medicare + Choice managed care organizations expressed several concerns regarding physician incentive plan reporting. Many volunteered that collecting the information represents a costly and time-consuming burden for their physician providers. Even though many managed care organizations credit CMS for designing an electronic reporting format, all managed care organizations face a physician incentive plan reporting burden, even if their plans do not offer incentives to their providers. Our survey reveals that 24 of 227 managed care organization contracts had no incentives at all in 1999. (Appendix B contains CMS' instructions to managed care organizations for submitting 1999 physician incentive plan data.)

While we did not independently verify their estimates, managed care organizations with 22 Medicare + Choice contracts report that their direct physician incentive plan reporting expenses averaged nearly $25,000 in 2001. These plans report using between 150 and 550 staff hours to collect, consolidate, review for obvious errors, and enter the data, with costs ranging from $30 to $50 per hour. Humana, which operates multiple Medicare + Choice plans, estimates expending 550 hours and $86,000 to gather the necessary physician incentive plan reporting data in 2001.

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Some managed care organizations pass the burden of completing the physician incentive plan reporting on to providers. In States like California where physicians may participate in many managed care plans, this burden can be substantial, and as previously noted, may result in inaccurate physician incentive plan reporting. To mitigate the burden on their providers, the California Medicare + Choice plans created the Interagency Coordinated Effort. The Interagency Coordinated Effort makes a single request to providers for physician incentive plan information, secures an attestation of accuracy from the providers, and distributes the results to each managed care organization with which the providers are associated. This effort substantially reduced the "hassle factor" for providers, according to California managed care organizations. However, even this cooperative effort is expensive for managed care organizations. Kaiser Permanente, with mainly salaried physicians in its plan, estimates spending $30,000 to collect and report the calendar year 2001 physician incentive plan data.

Both CMS and managed care organizations already collect information which could help determine if incentive arrangement problems exist

While the current physician incentive plan reporting serves as a useful reminder to managed care organizations of the need for stop-loss coverage, its effectiveness is limited. The current physician incentive plan reporting does not capture specific information about when or why managed care organizations pay physician incentives or how these incentives may relate to patient care. Nevertheless, data that could help CMS to determine this can be obtained for this purpose.

The Secretary has established a moratorium on new encounter data reporting while the department assesses the priorities and burdens of such reporting requirements. We found several examples where physician incentive data can be related to quality of care which CMS can consider using once the moratorium is lifted. During its onsite reviews, CMS could examine this information for potential outliers or trends, recognizing that not all anomalies in treatment are necessarily related to physician incentives. In the following sections, we identify several types of these data.

Managed Care Incentives for Meeting Targeted Financial or Utilization Goals

The following table represents information about utilization and referral targets reported to us by managed care organizations which the CMS physician incentive reporting and onsite review process does not collect. The Medicare + Choice managed care organizations identified the number of contracts they had that paid incentives for meeting utilization and referral targets. Utilization goals involve managed care organizations identifying a targeted dollar amount of medical expenditures for a specific time period. If members' use of medical services results in expenditures that equal or exceed the targeted amount, no incentive is paid. Conversely, if the actual medical expenditures are below the target, managed care organizations use this surplus to pay the providers a bonus. Frequently, the managed care organizations and the contractee share this surplus.

Utilization and Referrals						
Target Areas	**Contracts with Individual Physicians**		**Contracts with Physician Groups**		**Contracts with Intermediate Entities**	
	Yes	No	Yes	No	Yes	No
Financial Goals	44	126	73	109	78	91
Utilization Goals	24	146	29	153	31	138
Emergency Room Utilization	32	138	26	156	30	139
Hospitalization Utilization	39	131	52	130	44	125
Referrals to Specialists	20	150	25	157	26	143

Targeted utilization incentives may induce providers to withhold necessary medical treatment, hospitalizations, or referrals. To discourage restricting access and utilization of appropriate care, some managed care organizations reported limiting the amount contractees may collect from these types of incentives.

Linkages Between Physician Incentives and Access to Quality Care

There are several quality indicators CMS currently uses to help determine whether Medicare managed care beneficiaries have access to appropriate medical services. The CMS currently monitors consumer satisfaction, access to care, and quality of care using performance measures such as the Health Plan Employer Data and Information Set, the Medicare Health Outcomes Survey, and the Consumer Assessments of Health Plans Study surveys. The CMS also has developed the Quality Improvement System for Managed Care Standards and Guidelines. These performance measures were developed to strengthen managed care organizations operation and performance in the areas of quality measurement and improvement, and the delivery of health care and enrollee services.

While CMS regional offices review these quality factors in determining whether managed care organizations provide access to quality care for Medicare patients, under the current physician incentive plan reporting process, CMS has not routinely examined these quality or performance measures to help determine if access or underutilization of services are affected by these incentives. Half of the CMS regional offices we surveyed indicated that using multiple sources of information as indicators of potential incentive arrangement problems would be most effective in examining quality of care issues during their onsite reviews. They also felt irregularities revealed by reviewing the nature of the incentives could be a basis for a more extensive onsite review of physician incentive plans. Most thought the physician incentive plan information currently collected should be supplemented with information from other sources in order to be useful. New CMS

onsite review guidelines direct regional offices to link physician incentive plan information with these other sources of quality and access indicators during their reviews.

Managed Care Incentives for Meeting Targeted Quality Goals

In addition to CMS' physician incentives information, Medicare + Choice managed care organizations routinely gather information to internally monitor their own performance that might also suggest problems with physician incentive plans. For example, some managed care organizations track information such as beneficiary disenrollment rates and underutilization trends as well as maintaining and reviewing beneficiary complaint logs. The physician incentive plan regulations also require Medicare + Choice managed care organizations to conduct consumer satisfaction surveys when their contracts place physicians or physician groups at substantial financial risk. The CMS regional offices do not routinely use these data from Medicare + Choice plans in reviewing the appropriateness of physician incentive plans.

For example, the Patient Access and Services table below illustrates the number of Medicare + Choice contracts that managed care organizations reported to us containing incentives for patient access and service targets. (See Appendix C for other quality incentives managed care organizations reported to us). Some managed care organizations give incentives to providers that keep their practice open to new Medicare beneficiaries. Also, some managed care organizations pay incentives to providers achieving both specified financial goals and targeted satisfaction levels. One managed care organization volunteered that it would not pay an incentive if a provider met the financial or utilization goals without meeting a specified level of patient satisfaction.

Patient Access and Services						
Target Areas	**Contracts with Individual Physicians**		**Contracts with Physician Groups**		**Contracts with Intermediate Entities**	
	Yes	No	Yes	No	Yes	No
Increased Hours for Patient Care	22	148	10	172	3	166
Patient Satisfaction	36	134	28	154	17	152
Accepting New Patients	26	144	17	165	6	163

The CMS is currently developing a data-driven system that will provide a more comprehensive view of managed care organization activities, including physician incentives. In addition to these quality measures, CMS is also involved in a major national initiative to reduce the administrative burden for health plans by simplifying reporting requirements and data requests.

RECOMMENDATION

The current CMS process that requires managed care organizations to annually report stop-loss coverage data for some incentive arrangements conveys the importance of risk protection to managed care organizations, providers, and provider groups who disclose this information. The current process is not designed to detect whether needed services are being restricted or otherwise affecting the access to medically necessary services.

We think the physician incentive plan process should be aimed more directly at ensuring Medicare + Choice beneficiaries' access to care. We recognize there is no single measure that captures medical underutilization, limiting referrals to specialists, or otherwise withholding needed medical services. And, while a direct causal link between incentives and access to care would be difficult to establish, measures already used by CMS and managed care organizations could be identified that, either singly or in aggregate, may indicate whether beneficiaries' care is influenced by Medicare + Choice incentive arrangements.

The CMS should replace the current reporting system with other approaches that are more effective and less burdensome

The CMS should terminate the current reporting process which represents a considerable expense of funds, staff, and computer time. Eliminating the annual physician incentive plan reporting is consistent with CMS' desire to lessen administrative burdens for Medicare + Choice managed care organizations and Medicare providers. We recommend CMS take the following steps to replace the physician incentive plan process.

Require attestations regarding incentives in all managed care organization and downstream provider contracts

To address congressional concerns that managed care organization incentives may negatively impact Medicare beneficiaries' access to appropriate medical care, CMS could require managed care organizations to obtain and retain attestations from all their contractees that incentives cannot be used to limit access to medically necessary care. These attestations can be made part of the managed care organization contracts with physicians, provider groups, and intermediate entities. Physician groups and intermediate entities should also comply with this requirement, as well as any downstream contracts they may have. The managed care organizations should obtain new attestations only whenever contracts affecting Medicare beneficiaries are changed.

Periodically verify the accuracy of attestations and presence of stop-loss coverage, including downstream providers where incentives are involved

The CMS regional offices could include verification of managed care organization incentive attestations and appropriateness of stop-loss coverage during their managed care organization onsite reviews. During these reviews, if a managed care organization contracts with provider groups or intermediate entities, CMS regional offices could select a sample of downstream provider contracts to review for incentive attestations and stop-loss coverage. In addition, CMS could ensure that any incentives or withholds related to meeting goals for achieving financial, utilization, emergency room, hospitalization, or referral targets do not restrict Medicare beneficiaries' access to needed medical services or quality medical care.

Identify data already collected by managed care organizations that may indicate if Medicare + Choice beneficiaries are being denied access, services, or referrals as a result of physician incentives

The CMS managed care review guide used by regional offices requires examination of utilization reviews and physician incentive plans to ensure that existing practices do not interfere with or cause delays in services. We believe the type of incentive data we collected in our survey from managed care organizations relating to financial and utilization goals could serve as potential leads for CMS regional offices in helping them make these determinations.

The CMS must also make determinations about the quality of care Medicare + Choice plans provide to Medicare patients. We believe the types of quality incentives these plans identified in our survey may also help CMS in their Medicare + Choice quality decisions. In combination with this data, CMS regional offices could request and review beneficiary complaint logs, underutilization studies, or other data that managed care organizations already maintain that may indicate whether or not providers withhold appropriate medical treatment from beneficiaries as a result of physician incentives.

This recommendation is consistent with CMS's effort to reduce managed care organizations' administrative burdens in that it recommends the use of data already collected by managed care organizations. The CMS should consider the need to identify appropriate and inappropriate incentives as they formulate a more streamlined approach to data collection and use of the data in evaluating the performance of managed care organizations.

AGENCY COMMENTS

We received comments on this report from CMS. Additionally, technical comments were provided and incorporated where appropriate. CMS concurs with our recommendation and are modifying the PIP regulations to reduce administrative burden on Medicare + Choice managed care organizations. CMS is also continuing to implement performance assessments that more directly measure health care quality and access in a managed care setting. Comments can be found in Appendix D.

APPENDIX A

Glossary of Terms

All definitions were taken or adapted from the CMS website (except where noted by an asterisk*).

Bonus — A payment a physician or entity receives beyond any salary, fee-for-service payments, capitation or returned withhold. Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk.

CAHPS (Consumer Assessments of Health Plans Study) — A major national initiative, sponsored by the Agency for Health Care Research and Quality, to develop a set of standardized consumer satisfaction instruments, user manuals, and recommended report formats. Surveys include both a standardized satisfaction survey for enrollees and a disenrollment survey that gathers information from beneficiaries leaving a health plan about their experiences receiving care and their reasons for leaving the plan. The CMS requires all Medicare contracting managed care organizations (MCOs) to participate in the CAHPS surveys.

Capitation — A set dollar payment per patient per unit of time (usually monthly) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include a physician's own services, referral services or all medical services.

Downstream provider* — Refers to any physician, provider group, or intermediate entity who contracts with these entities to provide medical services to MCO patients. This provider does not contract directly with the Medicare + Choice MCO, it is a subcontractor.

Global risk* — Transfers financial risk to the provider for all medical services to a beneficiary.

HEDIS (Health Plan Employer Data and Information Set) — Set of standardized performance measures designed to assess the quality of health care and services provided by managed care plans. The HEDIS was developed by the National Committee for Quality Assurance (NCQA) to provide purchasers and consumers with the ability to evaluate the quality of different health plans, and to make their plan decisions based upon demonstrated value rather than simply on cost.

Intermediate entities — Entities which contract between an MCO or one of its subcontractors and a physician or physician group, other than physician groups themselves. An IPA is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

HOS (Medicare Health Outcomes Survey) — Formerly known as Health of Seniors, this HEDIS measure is the first outcomes measure to be used in the Medicare population and represents the largest survey effort ever undertaken by CMS. All managed care plans with Medicare + Choice contracts are participating. It is a longitudinal, self-administered survey which CMS plans to use to focus quality improvement activities, to provide comparative information for beneficiaries to make informed decisions when choosing a health plan, and to assess the performance of health plans and integrate valid and reliable performance measures into the contracting process.

Panel size — The number of patients served by a physician or physician group. If the panel is greater than 25,000 patients, then the physician group is not considered to be at substantial financial risk because the risk is spread over the large number of patients. Stop-loss and beneficiary surveys would not be required.

Percent of premium* — Payment a physician or entity receives that is a predetermined percentage of overall revenue from beneficiary premiums.

Physician group — A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.

Physician incentive plan — Any compensation arrangement at any contracting level between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare or Medicaid enrollees in the MCO. Managed Care Organizations must report on physician incentive plans between the MCO itself and individual physicians and groups and also between groups or intermediate contracting entities (e.g. Physician-Hospital Organizations) and individual physicians and groups. The MCO only needs to report the details on physician incentive plans between groups and individual physicians if those physicians are placed at substantial financial risk by the group's incentive arrangement.

Potential payments — The maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. These payments include amounts paid for services furnished or referred by the physician/group, plus amounts paid for administrative costs. The only payments not included in potential payments are bonuses or other compensation not based on referrals (e.g., bonuses based on patient satisfaction or other quality of care factors).

QISMC (Quality Improvement System for Managed Care Standards and Guidelines) — Key tools for use by CMS and States in implementing the quality assurance provisions of the Balanced Budget Act of 1997, as amended by the Balanced Budget Refinement Act of 1999. For Medicare, the QISMC document is equivalent to a program manual. As such, the document represents CMS' administrative interpretation of the Medicare + Choice requirements relating to an organization's operation and performance in the areas of quality measurement and improvement and the delivery of health care and enrollee services. The standards and guidelines are derivatives of the regulatory requirements, and are necessary to implement them

.

Referral services — Any specialty, inpatient, outpatient or laboratory services that are ordered or arranged, but not furnished directly. Situations may arise where services not normally considered referral services will need to be considered referral services for purposes of determining if a physician/group is at substantial financial risk. Also, if a physician group contracts with an individual physician or another group to provide services which the initial group cannot provide itself, any services referred to the contracted physician/group should be considered referral services.

Stop-loss coverage — Used to ensure that providers face only certain financial limits in treating Medicare managed care beneficiaries. The CMS considers $5,000 for outpatient services and $30,000 for inpatient treatment to be reasonable stop-loss limits. Without stop-loss protections, providers treating one or more high cost patients could face catastrophic financial repercussions.

Organizations whose contracts or subcontracts place physicians or physician groups at substantial financial risk must ensure that those providers have either aggregate or per-patient stop-loss protection. The aggregate stop-loss protection requires coverage of at least 90 percent of the costs of referral services that exceed 25 percent of potential payments. The per-patient stop-loss protection requires coverage of 90 percent of the costs of referral services that exceed specified per-patient limits.

Substantial financial risk — An incentive arrangement that places the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. The CMS considers providers to be at substantial financial risk when 25 percent or more of their potential MCO reimbursement depends on referrals they may make or services they may provide.

Withhold — A percentage of payments or set dollar amounts that are deducted from a the service fee, capitation or salary payment, and that may or may not be returned, depending on specific predetermined factors.

APPENDIX B

HCFA PIP reporting instructions to MCOs

MEDICARE MANAGED CARE ORGANIZATIONS
PHYSICIAN INCENTIVE PLAN DISCLOSURE INSTRUCTIONS

General Instructions for Submission: Hard copy Physician Incentive Plan (PIP) Disclosure is required only for new applicants for Medicare+Choice Contracts, except for Private Fee For Service Plans or non-network Medicare Savings Account Plans. Organizations that already hold a Medicare contract with HCFA will benefit from disclosing electronically. (see PIP Requirements for 1999 on HCFA's web site: *www.hcfa.gov/medicare/physincp/pip-info.htm*)

A hard copy disclosure must be included in the completed application, as directed within the application form. The disclosure should represent physician incentive arrangements for providers within the Managed Care Organization's (MCO) network at the time the application is submitted. A Medicare PIP disclosure includes:

- The disclosure **Cover Sheet** - This sheet should be the *first page of the PIP submission.*
- **PIP Disclosure Form -** This form may be duplicated as many times as necessary to capture all of the arrangements in effect amongst the applicant's provider contractors and subcontractors.

Using the HCFA PIP Worksheet: The PIP Worksheet should be used as a guide in determining if there is substantial financial risk in any provider arrangement and to assist the MCO in entering data on the disclosure form. MCOs may modify the Worksheet for their internal use as long as the necessary information is captured that will document the data upon audit by regulators. Generally, a separate Worksheet should be used for each type of contractual relationship. Reproduce as many of these forms as needed. Do not submit the Worksheets, but retain them for review by regulators.

The MCOs should analyze the data from different providers to determine whether information from the same type of contracting entity can be aggregated for disclosure to regulators.

MCOs need to determine if they have received all information from their contractors down to the level of physicians, even if the providers bear no risk or there is no substantial financial risk.

- An intermediate entity should report arrangements with its medical groups and the medical groups' physicians. Even if there is no substantial financial risk between the MCO and the intermediate entity, the lower levels must be disclosed.
- A medical group should report arrangements with its physicians, even if there is no substantial financial risk between the MCO and the medical group.

Enter the information from the Worksheet on the appropriate lines on the Disclosure Form after checking the specific contractual relationship being disclosed.

Using the PIP Disclosure Form: At the top of the Disclosure Form, *print the name* of the MCO, give the Medicare contract number, and the reporting year.

Nine contractual relationships are listed. Disclose one type of relationship on each Form you complete. Submit as many Forms as you need to represent all of the arrangements that serve the MCO's Medicare enrollees.

(1) _____ MCO to physician group
(2) _____ MCO to intermediate entity
(3) _____ MCO to individual physician
(4) _____ Intermediate entity to physician group
(5) _____ Intermediate entity to physician
(6) _____ Physician group to physician group
(7) _____ Physician group to physician
(8) _____ Physician to physician
(9) _____ Intermediate entity to intermediate entity

Each submission from an MCO must include contractual relationships (1), (2) or (3), but MCOs may have multiple arrangements and need all three. Then the MCO must disclose the subcontracting arrangements to the level of the physician. All disclosures relating to one hierarchy of contracts should be stapled together. The hierarchies are:

Selection of: **(1) _____ MCO to physician group requires a disclosure of:**

(7) _____ Physician group to physician OR (6) _____ Physician group to physician group
If (6) is selected, you **must** have (7) to disclose incentives to physicians
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(2) _____ MCO to intermediate entity requires disclosure of :**

(4) _____ Intermediate entity to physician group OR
(5) _____ Intermediate entity to physician OR
(9) _____ Intermediate entity to intermediate entity
The intermediate entity can have multiple contracting arrangements.

If (4) is selected, you **must** have (7) to disclose incentives to physicians
If (9) is selected, you **must** have (4) or (5) to disclose incentives to subcontractors
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(3) _____ MCO to individual physician does not require any subcontract.**

There can be selection of: (8) _____ Physician to physician [this is not required]

Single or aggregate disclosure: The Disclosure Form may reflect a *single* incentive arrangement if that is a unique arrangement. However, MCOs should *aggregate* information on one Form for contractual arrangements that are substantially the same and the stop-loss requirements are the same.

For example, if an MCO contracts with 100 medical groups under a very similar capitation payment that does not pass referral risk to the groups, the MCO should check category one on the Disclosure Form and disclose all 100 on one Form. If 55 medical groups do not pass risk to their doctors and these 55 groups have a total of 450 physicians under this no risk compensation, then the MCO should check category 7 on a new Disclosure Form and disclose all 450 on the Form. Similarly, the MCO should disclose the physician group-physician incentive arrangements for the other 45 groups, aggregating those physicians who are placed at substantially the same risk and who have the same stop loss requirements, if the risk exceeds the SFR cutoff. Staple together all the forms that relate to the 100 medical groups.

Entering the information: After checking the relationship you are disclosing, follow the directions below.

1. On line 1.A., give the name of a single provider (e.g., the intermediate entity, physician group, or individual physician) when this is the party who receives payment under the provider contract to which the Disclosure Form applies.

   On line 1.B., give the number of aggregated providers whose arrangements are being disclosed. (See the discussion above.) Do not send lists of provider names. For example, if #1 is selected, then give the # of physician groups.

   Line 1.C. asks for disclosure of Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs). Please distinguish FQHC/RHCs by using a separate Disclosure Form to report each FQHC/RHC, however you may aggregate those with substantially the same incentive arrangements. If the MCO is owned or controlled by a consortium of FQHC/RHCs or has FQHC/RHCs in its network, be sure to indicate this on the cover sheet.

   Line 1.D. applies only to physicians of medical groups (selection of #7 contracting type) and asks for a breakout of the number of physicians who are members of the group and those who independently contract with the group. Members are typically owners, partners, or employees of the medical group.

   If either arrangement with providers that are intermediate entities (IE) is selected on the Disclosure Form (either #2 or #9), complete items 1.A - 1.C only since stop loss requirements do not apply to intermediate entities (IE). However, fully complete disclosures for IE's relationships with provider groups and their physicians (#4 and #7) and IE with individual physicians (#5) because stop loss requirements apply to these levels.

2. Question 2 identifies whether the incentive arrangement transfers any risk. A capitation payment is considered a transfer of risk for this question, even if the capitation is for services provided only by the contracting physician or physician group. [This information is found on Question 2a of the Worksheet.]

   Check "yes"or "no" as applicable. If "no" is checked, then this disclosure is complete. If "yes" is checked, identify the type of risk transfer; then go to Question 3.

   Risk transfer choices are: "capitation, bonus, withhold, percent of premium or other." *Check the appropriate choice* or choices; more than one choice should be checked if the arrangement has features of each type of risk-sharing.

   A choice of "Other" is provided if a combination of the four types of risk arrangement does not define the arrangement. For the purpose of this Disclosure Form, the obligation for the provider to fund deficits is considered as a "withhold." A bonus for low utilization of referral services is considered to be risk transference.

   The risk-sharing arrangement may be described briefly on the Disclosure Form, particularly if 'other' is selected. [This information is found on Question 3 of the Worksheet.]

3. Question 3 identifies whether risk is transferred for referrals. [This information is found on Question 2b of the Worksheet.] *Check "yes"or "no"* as applicable. A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services. If "no" is checked, then this disclosure is complete. If "yes" is checked, go to Question 4 to identify the type of risk transfer.

4. Question 4 identifies the type of risk-sharing arrangement. [This information is found on Question 3 of the Worksheet.] See #2 above for instructions on identifying risk arrangements.

5. The percentage of risk ***attributable to referrals only*** should be stated in Question 5. This percentage corresponds to the "% Of Total Compensation At Risk For Referrals" from Question 3 of the Worksheet. If the percentage is equal to or below 25 %, the arrangement is not considered to be at substantial financial risk and this disclosure is complete. If above 25 percent, proceed to Question 6.

6. Information for Question 6, about the number of patients, is found on Question 1 of the Worksheet. Specific criteria must be met before pooling is allowed, as stated in regulations. Any entity that meets all five criteria (below) required for the pooling of risk will be allowed to pool that risk in order to determine the amount of stop-loss required by the regulation. If the number of patients is 25,000 or fewer, then go to Question 7. If greater than 25,000, the disclosure is complete.

   (1) Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group (i.e., no contracts can require risk be segmented by MCO or patient category);
   (2) The physician or group is at risk for referral services with respect to each of the categories of patients being pooled;
   (3) The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);
   (4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by MCO or by Medicaid, Medicare, or commercial); and
   (5) The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

   Note that pooling and stop-loss requirements applicable to a group cannot be extended to a subcontracting level. For example:

   - A physician group has greater than 25,000 patients that meet pooling criteria.
   - This group contracts with another physician group, which has 25,000 or fewer patients and bears risk for referrals above 25%.

   The first group is exempt from stop-loss requirements; the second group must comply with stop-loss requirements and the MCO must comply with survey requirements.

7. For Question 7, note the type and the levels or thresholds of the stop-loss insurance if stop-loss coverage for the physician group or physician is required.

   Check the <u>type</u> of stop-loss, aggregate, individual per patient, or other coverage, and give the <u>threshold</u> as a *dollar amount*. Also, briefly describe the stop-loss coverage. If there is more than one threshold level, note that there are multiple levels and include an explanation. If "O" for other arrangements is checked or there are arrangements that merit explanation, describe the coverage (attach a sheet for additional space).

   A description should include whether the coverage is:

   (1) Combined (professional and institutional);
   (2) Broken down into institutional, professional and other components;
   (3) The deductible, co-insurance percentage, maximum liability/pay-out by the policy;
   (4) Whether the stop-loss coverage applies to all costs or only the cost of referral services; and

(5) Any other key features of the coverage.

This information is found in Question 5 of the Worksheet.

If providers can be aggregated because of the similarity of risk arrangements, the MCO should sort the providers by stop loss requirements and then use a separate Disclosure Form for each requirement. For example: 100 groups exceed the 25% risk threshold; 50 have a patient pool exceeding 25,000 (under a very similar risk arrangement); 25 have a patient pool of between 1,001 and 5,000 (under a very similar risk arrangement); and another 25 of these groups have a patient pool of between 8,001 and 10,000. The MCO should use three Disclosure Forms to represent the groups that aggregate into three stop loss requirements.

NOTE: For guidance and clarification on determining substantial financial risk, pooling of risk, and stop loss requirements, see HCFA's extensive 1997 PIP Qs & As document, available at HCFA's web site.

PUBLIC REPORTING BURDEN:

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0700. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503."

HCFA will accept copies of state-mandated submissions in lieu of the Disclosure Form if such submissions include all the necessary elements of information as required by HCFA and statute. MCOs may maintain records supporting the Disclosure Forms in any format, as long as these records sufficiently document the disclosure information the MCO submits and are available for inspection by appropriate regulators.

Cover Sheet

Managed Care Organization (MCO) Disclosure Compliance Package Under the Physician Incentive Regulation Submitted to Health Care Financing Administration (HCFA) or State Medicaid Agencies (SMA)

Name of MCO _____

Medicare Contract #H _____ (PIP applies to Medicare+Choice, except for PFFS and non-network MSA, and §1876 cost-based contractors)

MCO is owned/controlled by a Federally Qualified Heatlh Center or Rural Health Clinic (FQHC/RHC) or consortium of FQHC/RHCs or includes FQHC/RHCs in its network:

YES _____ **NO** _____

Printed Name of MCO Contact Person _____ **Phone #** _____

This represents our organization's disclosure compliance package submitted to HCFA or SMA. I certify that the information made in this disclosure is true, complete and current to the best of my knowledge, information and belief and is made in good faith.

Printed Name of CEO _____

Signature of CEO _____ **Date:** _____

Note: Please include this Cover Sheet as the first page of the MCO Disclosure Compliance Package.

PHYSICIAN INCENTIVE PLAN DISCLOSURE FORM

Managed Care Organization (MCO) Name: _____
Contract Number: H# _____
Reporting year _____

CHECK ONE - Use this Disclosure Form to disclose the incentive arrangement between the first party (in the list below) that makes payments under a provider contract to the second party (underlined on the list below) for services to the MCO's Medicare (or Medicaid) enrollees. Repeat forms as many times as needed to capture the various levels of contractual relationships. [1] For simplicity, "provider" is used here to refer to the second party. See instructions under "Single or aggregate disclosure" for aggregating either the first or second party. [2]

(1) _____ MCO to physician group

(2) _____ MCO to intermediate entity

(3) _____ MCO to individual physician

(4) _____ Intermediate entity to physician group

(5) _____ Intermediate entity to physician

(6) _____ Physician group to physician group

(7) _____ Physician group to physician

(8) _____ Physician to physician

(9) _____ Intermediate entity to intermediate entity

1. **The provider(s) named or counted should be the underlined provider in the line you checked above.**

   A. Name of Provider: _____
   Give name if one provider arrangement is being disclosed on this form.

   - OR -

   B. Number of Providers: _____
   Give # of providers who are aggregated on this form; e.g., if #1 is selected, then give the # of groups; physician groups can be aggregated if risk arrangements are substantially the same and stop loss requirements are the same.

1. C. Is provider an FQHC/RHC? **Y**es ____; **N**o ____
   If providers are aggregated, see instructions for disclosing FQHCs.

1. D. If #7 above is selected, give number of physicians who are:

   Members (e.g. owners, employees) of the group #_____ ; **C**ontracted with the group #_____
   These numbers must equal the number of physicians given in I.B.

NOTE: If either #2 or #9 is checked above, this form is complete since stop loss requirements do not apply to intermediate entities (IE). However, be sure to complete disclosures for the IE's relationships with provider groups and their physicians (#4 and #7) and with individual physicians (#5) because stop loss requirements apply to these levels.

2. Is risk transferred to the provider? **Y**es ____; **N**o ____
Note: A bonus for low utilization of referral services is considered to be risk transference.
If YES, check all the risk transfer methods with the provider and go to question 3.

Capitation ____; **B**onus ____; **W**ithhold ____; **P**ercent of Premium____; **O**ther ____
Note: Consider the obligation for the provider to fund deficits as a "withhold".
Describe briefly:

3. Is risk transferred for referrals? **Y**es ____; **N**o ____
Note: A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services.
If YES, then proceed to next question.

4. Check all the referral risk transfer methods with the provider and go to question 5.

Capitation ____; **B**onus ____; **W**ithhold ____; **P**ercent of Premium____; **O**ther ____
Note: Consider the obligation for the provider to fund deficits as a "withhold".
Describe briefly:

5. What percent of the total potential payment is at risk for referrals: _____%
If above 25% proceed to question 6; if 25% or below you have completed this disclosure.

6. Number of MCO patients served by the provider **or** the number of pooled patients, if patients can be pooled (see criteria for pooling in the instructions). Check one category:

A __ 1-1,000; **B** __ 1,001-5,000; **C** __ 5,001-8,000; **D** __ 8,001-10,000; **E** __ 10,001- 25,000; **F** __ 25,000+

If number is 25,000 or below, answer #7. If the number exceeds 25,000, you have completed this disclosure.

7. State the type and amount of stop loss insuring the physician group and/or physician:

Type: **A**ggregate ____; **I**ndividual ____; **O**ther ____ (describe)

Threshold: **P**rofessional $_____ ; **I**nstitutional $_____ ; **C**ombined $_____
Describe briefly:

*DO **NOT** SUBMIT THESE FORMS TO HEALTH CARE FINANCING ADMINISTRATION OR STATE MEDICAID AGENCIES. MCO OR OTHER ENTITY COMPLETING FORM SHOULD RETAIN WORKSHEET AND HAVE IT AVAILABLE FOR REGULATORS IN THE EVENT OF AN AUDIT.*

HCFA PHYSICIAN INCENTIVE PLAN WORKSHEET

Note: Each Worksheet should reflect a single incentive arrangement or an aggregate of multiple arrangements that are the same or similar.

The Worksheet should be completed for the contractual arrangements that will be in effect on January 1 of the disclosure year.

General Information:

_____

(Print name of entity completing this Worksheet - the first entity in the line checked below)

This Worksheet is being completed to describe the incentive arrangement between (check one below):

(1) _____ Managed Care Organization (MCO) to physician group
(2) _____ MCO to intermediate entity
(3) _____ MCO to individual physician
(4) _____ Intermediate entity to physician group
(5) _____ Intermediate entity to physician
(6) _____ Physician group to physician group
(7) _____ Physician group to physician
(8) _____ Physician to physician
(9) _____ Intermediate entity to intermediate entity

Specify parties to contract: _____
(the first entity in the line checked above)

and _____.
(the entity underlined in the line checked above)

[NOTE: If Worksheet covers multiple contracts, name parties on a separate attachment.]

For the purposes of the regulation, the following definitions should be used:

Intermediate Entity = a physician-hospital organization ("PHO"), integrated delivery system, or individual practice association ["IPA"] that subcontracts with physician groups or with another IPA.

Physician Group = a partnership, association, corporation, or other group that distributes income from the practice among members, or an IPA that contracts with individual physicians.

NOTE: If either #2 or #9 is checked above, stop loss requirements do not apply to intermediate entities (IE). Therefore, such entities may skip to the end of the worksheet and complete the signature and date information. However, be sure to complete disclosures for IE's relationships with provider groups and their physicians (#4 and #7) and with individual physicians (#5) because stop loss requirements apply to these levels.

Physician Group Member Panel Size: ***Estimated members as of contract year being disclosed.***

1.) State below the breakdown of total members served under the incentive arrangement(s) to which this Worksheet applies by patient type (e.g. Medicare, Medicaid, and commercial). Note: A physician group can pool to arrive at the total number of MCO members to which this Worksheet applies if the criteria described in the HCFA Disclosure Guidance or Disclosure Instructions are met. If pooling is used, attach an explanation of how it was done to the Worksheet.

Total Commercial members _____

Total Medicare members _____

Total Medicaid members _____

Total _____

Note: If the total Member Panel Size for commercial, Medicare and/or Medicaid exceeds 25,000, complete Worksheet questions 2-4, then skip to the end of the Worksheet and provide signature and date information. Retain the Worksheet for your records.

Physician Incentive Plan Information:

	Medicare	**Medicaid**
2a.) Does the payment arrangement transfer risk? For example, bonuses, withholds, and capitation (whether or not for referral services) transfer risk. Fee-for-service arrangements without withholds or bonuses do not transfer risk.	YES____	_____
	NO _____	_____
2b.) Does the physician incentive plan (e.g., capitation, withholds, or bonuses) cover services not furnished by the physician or physician group?	YES____	_____
	NO _____	_____

(Note: Bonuses or withhold arrangements based on utilization or cost factors are included in these compensation arrangements. Bonus arrangements based solely on quality or access factors are not considered.)

If response to 2a or 2b is NO, skip to last page and complete information about person completing form.

3.) If you answered YES to Question 2b, please check below the type or types of incentive(s) and fill in the percentage(s) where indicated and applicable. Note: If the contract does not limit the amount of risk for referral services to a set percentage, insert "100" as the percentage. Maximum compensation is defined as the maximum dollar amount that a physician or physician group might receive for either direct or referral services, or their administration. It does not include bonuses that are not related to referral levels. Maximum compensation means maximum possible theoretical compensation without regard to historical experience.

Medicare Arrangements:

line 1____**Withhold** ____% Withhold [where percent of withhold = maximum possible withhold $$ / maximum compensation $$]

line 2____**Bonus** *____% Bonus [where percent of bonus = maximum possible bonus $$ / maximum compensation $$]

* *Do not include bonuses based on quality or access in either the calculation of maximum possible bonus or the maximum compensation.*

line 3____**Capitation** **_____%** Capitation [where percent of capitation = maximum capitation $ entity is potentially liable for referral services / maximum compensation $$]

_____% Of Total Compensation At Risk For Referrals (add lines 1, 2& 3)

IF % OF TOTAL COMPENSATION AT RISK FOR REFERRALS > 25% ,
THIS IS SUBSTANTIAL FINANCIAL RISK

Maximum compensation = maximum $ amount that might be received.

The following information is requested of you on a voluntary basis. Bonuses unrelated to referral levels are not to be included in the determination of the referral risk percentage, but HCFA would like to learn more about their use in order to judge whether they should be included in the calculation in future years.

line 4 _____**Quality bonuses _____%** [where percent of bonus = maximum possible quality bonus $$ / maximum compensation $$]

Medicaid Arrangements:

line 1____**Withhold** ____% Withhold [where percent of withhold = maximum possible withhold $$ / maximum compensation $$]

line 2____**Bonus** *____% Bonus [where percent of bonus = maximum possible bonus $$ / maximum compensation $$]

* *Do not include bonuses based on quality or access in either the calculation of maximum possible bonus or the maximum compensation.*

line 3____**Capitation** **_____%** Capitation [where percent of capitation = maximum capitation $ entity is potentially liable for referral services / maximum compensation $$]

_____% Of Total Compensation At Risk For Referrals (add lines 1, 2& 3)

IF % OF TOTAL COMPENSATION AT RISK FOR REFERRALS > 25% ,
THIS IS SUBSTANTIAL FINANCIAL RISK

Maximum compensation = maximum $ amount that might be received.

The following information is requested of you on a voluntary basis. Bonuses unrelated to referral levels are not to be included in the determination of the referral risk percentage, but HCFA would like to learn more about their use in order to judge whether they should be included in the calculation in future years.

line 4 _____**Quality bonuses _____%** [where percent of bonus = maximum possible quality bonus $$ / maximum compensation $$]

Note: If no substantial financial risk is being transferred to providers who provide services to Medicare or Medicaid enrollees, complete the date and signature information at the end of the Worksheet.

Stop-Loss Information: **Fill in if % Of Total Compensation At Risk for Referrals Is > 25%**

If incentive arrangements place either a physician or physician group at substantial financial risk, there must be aggregate or per patient stop-loss protection. Aggregate stop-loss protection must cover 90% of the costs of referral services that exceed 25% of potential payments. Per patient coverage may be through either single combined coverage, or through separate coverage for institutional and professional services. Per patient stop-loss protection must cover at least 90% of the referral costs that exceed the following threshold, or attachment point, amounts:

Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Professional Limit
1-1000	$ 6,000	$10,000	$3,000
1,001 - 5000	$30,000	$40,000	$10,000
5,001 - 8,000	$40,000	$60,000	$15,000
8,001 - 10,000	$75,000	$100,000	$20,000
10,001 - 25,000	$150,000	$200,000	$25,000
> 25,000	none	none	none

4.) Name of carrier/entity(s) through which stop-loss is provided:

_____ ___ Is this carrier/entity:
stop-loss carrier
___ MCO
___ intermediate entity
___ physician

_____ ___ Is this carrier/entity:
stop-loss carrier
___ MCO
___ intermediate entity
___ physician

5.) Describe the stop-loss coverage that covers the incentive arrangement(s) that is being reported on this Worksheet, for:

	Medicare	**Medicaid**
(A) ***Professional services*:**		
Deductible	_____	_____
Co-insurance percent	_____	_____
Maximum liability	_____	_____

Does this cover (check one below):

Individual Physicians	YES	_____	_____
	NO	_____	_____
Physician Group(s)	YES	_____	_____
	NO	_____	_____

		Medicare	**Medicaid**
Is this stop-loss coverage:			
Per patient	YES	_____	_____
	NO	_____	_____
Aggregate	YES	_____	_____
	NO	_____	_____

For professional services, describe the services or nature of costs covered under the stop-loss, including any exclusions, variations in coverage amounts, and whether the stop-loss coverage applies to all costs or only referral costs. (If additional space is required for this response, attach additional pages.) _____

	Medicare	**Medicaid**
(B) ***Hospital/Institutional Services:***		
Deductible	_____	_____
Co-insurance percent	_____	_____
Maximum liability	_____	_____

Does this cover:

Individual Physicians	YES	_____	_____
	NO	_____	_____
Physician Group(s)	YES	_____	_____
	NO	_____	_____

Is this stop-loss coverage:

Per patient	YES	_____	_____
	NO	_____	_____
Aggregate	YES	_____	_____
	NO	_____	_____

For hospital/institutional services, describe the services or nature of costs covered under the stop-loss, including any exclusions, variations in coverage amounts, and whether the stop-loss coverage applies to all costs or only referral costs. (If additional space is required for this response, attach additional pages.) _____

		Medicare	Medicaid
(C) ***Combined (Professional and Institutional):***			
Deductible		_____	_____
Co-insurance percent		_____	_____
Maximum liability		_____	_____
Does this cover:			
Individual Physicians	YES	_____	_____
	NO	_____	_____
Physician Group(s)	YES	_____	_____
	NO	_____	_____
Is this stop-loss coverage:			
Per patient	YES	_____	_____
	NO	_____	_____
Aggregate	YES	_____	_____
	NO	_____	_____

For combined forms of stop-loss, describe the services or nature of costs covered under the stop-loss, including any exclusions, variations in coverage amounts, and whether the stop-loss coverage applies to all costs or only referral costs. (If additional space is required for this response, attach additional pages.) _____

Date and Signature Information

Printed name and title of person who completed the Worksheet: _____

Name of organization/employer of person listed above: _____

Telephone:_____

Date: _____

I certify that the information made in this disclosure is true, complete and current to the best of my knowledge and belief and is made in good faith.

_____

Signature

DO NOT SUBMIT THESE FORMS TO HEALTH CARE FINANCING ADMINISTRATION OR STATE MEDICAID AGENCIES. MCO OR OTHER ENTITY COMPLETING FORM SHOULD RETAIN WORKSHEET AND HAVE AVAILABLE FOR REGULATORS IN THE EVENT OF AN AUDIT.

APPENDIX C

Other Quality Targets Managed Care Organizations Pay Providers Incentives For

Our survey found some managed care organizations collect additional information about quality and access goals in addition to data related to financial targets. The CMS does not collect this information in its physician incentive plan reporting. The managed care organizations pay incentives for meeting goals in areas that we broadly categorized as preventive care services and disease management and other quality measures. Many Medicare + Choice managed care organizations use multiple incentive areas in their contracts with providers.

The following two tables represent each of the broad categories describing the quality goals managed care organizations reported to us. In each category there are specific incentive targets that managed care organizations use in contracts with individual physicians, physician groups, or intermediate entities. Since managed care organizations can use multiple types of incentives in their contracts, a single managed care organization contract can be represented more than once in each table.

The Preventive Care Services and Disease Management table shows the first category for which managed care organizations reported offering incentives. No managed care organizations reported using incentives for providing services to particular ethnic groups. However, incentives to treat or screen for specific illnesses (e.g., diabetes) may indirectly affect the health and well-being of particular ethnic groups.

Preventive Care Services and Disease Management						
Target Areas	**Contracts with Individual Physicians**		**Contracts with Physician Groups**		**Contracts with Intermediate Entities**	
	Yes	No	Yes	No	Yes	No
Treating Chronic Illnesses	29	141	24	158	21	148
Immunizations	21	149	21	161	18	151
Diabetes Eye Exams	18	152	24	158	21	148
Cancer Screening	20	150	25	157	21	148
Hypertension Screening	16	154	16	166	13	156
Preventive Care Goals	25	145	30	152	27	142
Services for Particular Ethnic Groups	0	170	0	182	0	169

The following table demonstrates that managed care organizations target areas like continuing education to encourage providers to remain knowledgeable in current medical practices and technology. The managed care organizations reward providers for medical charts thoroughness to help ensure records are current and organized. Thorough medical records facilitate quality medical care and also allow other managed care organizations providers to obtain accurate medical information to appropriately treat beneficiaries.

Other Quality Indicators						
Target Areas	**Contracts with Individual Physicians**		**Contracts with Physician Groups**		**Contracts with Intermediate Entities**	
	Yes	No	Yes	No	Yes	No
Continuing Education	28	142	21	161	19	150
Medical Charts Thoroughness	21	149	12	170	2	167

CMS Comments on this Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 14 2002

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Physician Incentive Plan Reporting for Medicare+Choice Organizations* (OEI-05-00-00010)

Thank you for the opportunity to review and comment on the above-referenced draft report concerning physician incentive plan (PIP) reporting for Medicare+Choice (M+C) organizations.

The Centers for Medicare & Medicaid Services (CMS) staff has decided to modify the PIP reporting system requirements in order to reduce the administrative burden on M+C organizations. When the PIP requirements were enacted, the Congress expressed concern that financial incentives could lead to physicians hesitating to provide needed referral services. Our decision to modify the reporting requirements may raise concerns that this modification could lead to a reduction in the quality of care provided to, and received by beneficiaries. However, we have taken a number of steps to improve the quality of care provided by M+C organizations, such as the collection of Health Plan Employer Data Information Sets and the Consumer Assessment of Health Plans Survey. We have also implemented a number of other quality improvement projects. These improved quality assessments provide direct measures of quality and access that could eliminate the need to receive annual reports on PIP arrangements. In addition, this proposed approach would be consistent with reporting requirements of private accrediting organizations, such as the National Committee for Quality Assurance which only reviews incentive plans when investigating quality of care problems.

The CMS concurs with OIG's recommendation that the current PIP reporting system be replaced with other approaches that are more effective and less burdensome. Therefore, we have informed the M+C organizations that 2002 PIP disclosure is delayed until further notice. We are working to modify the PIP regulations at 42 CFR 422.208/210 in order to reduce the administrative burden on M+C organizations.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. We look forward to working with OIG on this and other issues pertinent to M+C organizations.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of William C. Moran, Regional Inspector General for Evaluation and Inspections in Chicago and Natalie Coen, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

Joe Penkrot, *Project Leader*
Marco A. Villagrana, *Lead Analyst*
Erin Guay, *Program Analyst*
Tricia Fields, *Program Analyst*
Linda Frisch, *Program Specialist*
Tricia Davis, *Program Specialist*