

Special Committee on Managed Care

Federation of State Medical Boards of the United States, Inc.

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 1998.

Preamble

In April 1996, Federation President James E. West, MD, established a Special Committee on Managed Care to evaluate the impact of managed care on the medical regulatory system. President West directed the committee to

- evaluate current relationships between managed care organizations (MCOs) and state medical boards to determine the effectiveness of such relationships in providing an appropriate degree of public protection;
- determine what data collected by managed care organizations may be used by state medical boards in assessing quality of care rendered by physicians in such organizations and how medical boards may access such data;
- review the different forms of contractual relationships between managed care organizations and physicians and determine which types of contracts, if any, might endanger public health and welfare; and
- evaluate methods used by managed care organizations in selecting/deselecting physicians for participation and the effect that minor disciplinary actions taken by state medical boards might have on the deselection process.

President West also charged the committee with developing recommendations regarding

- appropriate mechanisms through which medical boards may establish relationships with managed care organizations;
- rules/requirements that state medical boards should develop regarding the practice of medicine in managed care organizations which may enhance public protection; and
- alternative forms of discipline to maintain public protection while protecting the physicians against undue exclusion from participation in managed care organizations.

The committee met in August 1996, February 1997, May 1997 and September 1997. To ensure a complete and objective report, the committee solicited input from the following organizations:

- The American Medical Association provided information about contractual provisions contained in physician contracts with MCOs that could potentially harm patients.
- The Kaiser Permanente Foundation, representing the American Association of Health Plans, shared information about its physician credentialing and medical director performance evaluation systems.
- The National Committee on Quality Assurance (NCQA) provided information regarding NCQA standards for physician recredentialing, complaint processing and appeals processes.

The committee agreed on three fundamental guiding principles in fulfilling its charge.

1. The primary responsibility of a state medical board is to protect the public from the incompetent, unprofessional, improper and unlawful practice of medicine.

2. The authority for state medical boards to regulate medical practice is determined by each state's relevant statutes and/or administrative rules.
3. The committee's conclusions and recommendations would be developed within the framework of the medical profession's code of ethics, which holds that the doctor must always be an advocate for the patient in matters of the patient's health and welfare and, therefore, the doctor/patient relationship must be protected from conflicts of interest.

Section I: Objectives

The committee identified the following objectives:

- A. Include in its final report for distribution to state medical boards:
 1. a glossary of pertinent terms
 2. an index of contractual clauses/types that could endanger the public's health and welfare
 3. a listing of data collected by the managed care industry which may be useful to state medical boards in assessing quality of care rendered by physicians in such organizations and how medical boards may access such data
 4. an assessment of methods used by managed care organizations in selecting/deselecting physicians for participation
 5. recommendations for establishing liaison relationships with managed care organizations to ensure an appropriate degree of public protection
 6. recommendations regarding the use of alternative forms of discipline by state medical boards which maintain public protection while protecting the physicians against undue exclusion from participation in MCOs
- B. Develop recommendations that will improve the sharing of information between state medical boards and managed care organizations and their regulatory bodies.
- C. Develop strategies that medical boards may use to ensure decisions concerning precertification review or utilization review and appropriateness of care are made by licensed physicians accountable to the state medical board.
- D. Develop language for inclusion in the Federation policy document, *A Guide to the Essentials of a Modern Medical Practice Act*, that strengthens medical boards' regulation of physician activity within managed care networks.
- E. Develop strategies for use in monitoring state and federal legislative initiatives regarding managed care that restrict or impact a medical board's ability to license and discipline physicians.
- F. Develop and implement educational opportunities for medical board members and executive directors, policymakers of managed care organizations and the public regarding the committee's recommendations. Such educational programs may include regional workshops, sessions at the annual meeting or articles in the *Bulletin*.

Section II: Committee Deliberations

A. Relations Between State Medical Boards and MCOs

The Federation conducted a survey confirming that medical boards currently do not have regulatory oversight of MCOs. Rather, MCOs are generally accountable to a state's department of insurance or department of corporations. There was careful discussion regarding whether or not medical boards should seek out responsibility for regulating MCOs. The committee agreed that while there may be need for further and better state regulation of MCOs, to bring this function under the wing of state medical boards would be extremely difficult, could not be accomplished quickly and might even be detrimental to the current function of many state medical boards. Therefore, the committee determined early on to confine its deliberations and recommendations to the regulation of physicians. Regulation of MCOs by state medical

boards would require major legislative changes and major overhaul of the functions of state medical boards.

In determining the types of informal relationships that may exist between state medical boards and MCOs, committee members reviewed models from California, Maryland and New Jersey that demonstrated interagency relationships between the medical board and the state agency responsible for regulating MCOs. It was apparent that few medical boards have established relationships with managed care organizations or the agencies with responsibility for regulating them.

The lack of either formal or informal relationships between medical boards, MCOs and their responsible regulatory agencies may not adequately protect the public, particularly when a quality of care issue involving a physician arises. In order for medical boards to protect the public from physicians who are violating the applicable medical practice act, boards must collaborate with other state agencies to obtain information concerning physicians cited in quality of care complaints. At present, MCOs report only what the law requires.

MCOs gather mountains of information concerning physician practice patterns. In its review of data collection practices used by MCOs, the committee determined that, if all data collected were reported to state medical boards, boards would be overwhelmed trying to glean significant data from that which has no bearing on the physician's ability to practice competently. Specific information regarding MCO physicians who are being investigated or disciplined by the MCO for quality of care issues should be reported to the state medical board. The committee agreed that medical boards should have access to physician performance data for investigative purposes.

The committee discussed whether medical boards have jurisdiction over physicians whose positions as MCO medical directors requires them to render decisions that potentially affect patients' medical care. Critical to this discussion is the question of whether or not the determination of medical necessity is the practice of medicine. Because medical directors and other MCO employees apply medical judgment in determining if a proposed treatment is necessary, the committee agreed that the determination of medical necessity is in fact the practice of medicine. The committee determined that MCO employees who evaluate and determine a patient's need for medical treatment should be licensed physicians accountable to the medical board in the jurisdiction in which the health plan enrollee resides. Such a requirement will give state medical boards jurisdiction to investigate complaints arising from medical precertification decisions made by MCO medical directors.

B. Physician Contractual Arrangements

The committee recognized the positive influence that managed care could have on the U.S. health care delivery system, and cited the following as having particular potential for improving care:

1. prevention of unnecessary services to save money
2. managed formularies to preserve effectiveness of newer antibiotics
3. outcome studies to help physicians determine efficacy of experimental therapies
4. regular peer review for quality of care
5. inspection of physician office practice
6. reporting of substandard care
7. more data on patient satisfaction
8. increased emphasis on preventive medicine
9. emphasis on quality credentialing processes
10. increased home health services
11. increased patient compliance due to decreased cost

The committee reviewed a series of provisions contained in physician contracts routinely used by the managed care community. Many of these provisions could result in patient harm because they either restrict the physician's ability to communicate with his or her patients, or create a conflict of interest between the patient's health and the organization's economic standing. Potential problem areas include

1. gag rules;
2. economic advantage to physicians to deny service or referral;
3. bonuses to physicians based on economic performance;
4. denials based on cost rather than need;
5. if refers outside of network, physician has to indemnify plan;
6. if provides non-covered services, physician cannot recover payment from patient;
7. physician sanctions for failure to adhere to guidelines;
8. deselection, destroying doctor-patient relationship;
9. unavailability for or untimely approval of emergency care;
10. delays in decisions due to preauthorization requirements;
11. delays in diagnosis due to delayed approval of needed testing;
12. external control over physician decision-making;
13. care by non-physicians;
14. medical decisions by non-physicians;
15. rationing of care due to prioritization;
16. limited referral sources;
17. limited formularies;
18. limited services for chronic care, mental health;
19. early hospital discharge;
20. unilaterally changing plans/contracts; and
21. itinerant surgery by contracted physicians.

C. National Organizations Representing the Managed Care Industry

A representative of the Kaiser Permanente Foundation, representing the American Association of Health Plans (AAHP), described its mission and role in the managed care industry. This organization serves primarily as a trade association, has no real enforcement powers, and, therefore, may be of little help in solving the problems identified by the committee.

The NCQA, on the other hand, accredits MCOs. Many states use NCQA standards as the foundation for developing their MCO licensing standards. Fifty-five percent of MCOs have achieved NCQA accreditation by receiving a passing score on a compliance survey with an extensive list of criteria. Such accreditation is highly sought after, since it makes an MCO much more marketable. Because of the above, the committee determined that NCQA should be encouraged to include standards that would require reporting of quality of care issues to state medical boards. Additionally, other criteria protective of the public might become part of the standards under the urging of FSMB. Even if these efforts were successful, however, it must be remembered that NCQA accreditation (a passing score) could be achieved without complying with many of the criteria important to the Federation.

D. Selection For and Deselection From MCO Physician Panels

MCOs choose to enter into or terminate physicians' contracts for a variety of reasons. Some decisions are based on business factors such as a reduced need for specialists, the physician's inability to appropriately manage costs, or in some cases, because the physician has been sanctioned by a state medical board. Often, however, an MCO's decision to hire or fire a physician is based on quality of care issues, such as the physician's inability to abide by or meet the MCO's quality of care standards.

This practice raises concerns. First, MCOs are not likely to notify state medical boards when they deselect physicians for quality of care issues, thereby crippling a medical board's ability to appropriately protect the public from these practitioners. Second, deselection by multiple MCOs based on minor state medical board actions, even non-disciplinary actions, may effectively put a physician out of business.

As a result, medical boards are being pressured to modify their sanctioning procedures by physicians who may be negatively impacted when MCOs base their selection/deselection decisions solely on the fact that a sanction occurred, without consideration for why the sanction was given. In an effort to assist these physicians, some state medical boards have developed and are using sanctions that are structured as confidential arrangements between the physician and the medical board. As such, information about these types of actions is not included as a matter of public record, and, therefore, is not available to MCOs and the public. This practice could potentially undermine public trust in the medical regulatory system as well as subvert the interstate exchange of information which is critical to effective regulation of the medical profession. Prior to deselection, a physician must be granted due process by the MCO. NCQA has promulgated standards to require due process in this situation. The committee believes that these standards must be enforced.

Should state medical boards alter their actions based on the above consideration? In states with open meeting laws the question is moot, since MCOs act on the cases presented rather than on a specific board action. In states where the public is informed only of final board actions, however, the specific action taken could have a profound effect on the physician's future. In spite of this, the committee reaffirmed that the medical board's primary responsibility is to protect the public, not the physician, and the possibility of deselection, even though an untoward result, should not enter into a board's disciplinary process.

Section III: Recommendations

- A. State medical boards should establish mechanisms to facilitate regular communication between the board, the MCOs operating within the state and the government agency through which the MCOs are regulated. Such mechanisms may include
 1. a listing of the names and addresses of managed care organizations and their medical directors;
 2. letters of agreement to facilitate reporting of disciplinary actions involving a quality of care issue taken by an MCO against a licensed physician;
 3. formal reporting mechanisms for state medical boards to obtain information regarding physician quality of care complaints collected by the regulatory agency with jurisdiction over MCOs; and
 4. regular liaison meetings involving representatives from the association representing MCOs in a state, the state agency with regulatory responsibility over MCOs and the state medical board.
- B. State mandatory reporting laws must be clarified and/or amended to require MCOs to report physician quality of care issues, physician impairment and physician deselection, and the reason therefor.
- C. State medical boards, through legislative or regulatory process, should amend their medical practice acts or appropriate statutes to include the determination of medical necessity or decisions affecting the diagnosis and/or treatment of a patient as the practice of medicine. Further, MCO employees with the ultimate responsibility to make such determinations must hold a current and unrestricted medical license in the state in which the patient of the plan resides.
- D. State medical boards must, through legislative or regulatory process, require that MCO medical directors hold current and unrestricted medical licenses in the states in which the patients of the plan reside.
- E. State medical boards should support legislation against contractual provisions that are potentially harmful to the public, including but not limited to the use of gag rules and economic incentives to restrict care.
- F. State medical boards should modify their medical practice acts or appropriate statutes to include as unprofessional conduct, subject to disciplinary action, the following actions when such actions are taken for the sole purpose of positively influencing the physician's or plan's financial well-being:

- failure to refer, failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service or failure to refer to an appropriate provider.
- G. State medical boards should encourage the public to report complaints concerning the quality of care received from a physician participating in a managed care network to the state medical board as well as to the managed care organization in which the physician is participating.
 - H. State medical boards should encourage medical schools in their jurisdiction to educate residents and students about ethics of decision-making in a managed care environment.
 - I. State medical boards, recognizing their roles as public advocates, should not alter the way in which they sanction or report physicians to protect those physicians from negative economic ramifications resulting from MCOs' use of physician disciplinary information. Boards should educate their resident MCOs about the significance of various board actions in an effort to prevent inappropriate deselections.
 - J. The Federation of State Medical Boards should encourage the American Medical Association, the American Osteopathic Association, and appropriate public citizens' groups to advocate on behalf of the medical community to ensure that physicians either not selected by or deselected from managed care panels are provided appropriate due process, particularly when that selection is a result of a minor action taken against a physician by the state medical board.
 - K. The Federation of State Medical Boards should monitor state/federal legislation related to managed care that would impact medical boards' ability to protect the public through licensing and disciplining physicians. States should report any such legislative activity to the Federation for tracking.
 - L. The Federation of State Medical Boards should establish regular communication with appropriate national organizations that interface with the managed care industry, including but not limited to the NCQA, the Joint Commission on Accreditation of Healthcare Organizations and the American Association of Health Plans.
 - M. The Federation of State Medical Boards should conduct an annual review of standards set by NCQA pertaining to physician performance issues and communicate to NCQA any concerns regarding those standards, including recommending additions or changes to enhance public protection. Ideally, the Federation of State Medical Boards should have a seat on the NCQA.

Section IV. Conclusions

While the concept of managed care has existed for almost half a century, only since the mid-1980s have MCOs made significant strides in influencing how health care is delivered in the U.S. MCOs, in general, contribute to containing the cost of health care in the United States, encouraging preventive medicine and developing useful comparative data measurements regarding physician performance.

However, for all the potential positive influences that managed care may have, significant concerns exist regarding cost containment systems used by MCOs that encourage physicians to ration care in exchange for greater monetary rewards. More and more states are choosing to deal with these concerns through legislative means. In fact, at the close of the spring 1997 legislative session, 13 states have passed patient protection acts that include, among other provisions, bans on the use of gag clauses and financial bonuses based on low utilization patterns.

MCO medical directors are employees who make decisions for their employers on whether or not procedures are medically necessary. Such decisions are not insurance decisions, but rather medical decisions because they require the physician to apply medical judgment. *Murphy v. Board of Medical Examiners of the State of Arizona*, 247 Ariz. Adv. Rep. 35, 949 p. 2d 530 (Ariz. App. 997), Rev. Denied (Jan. 21, 1998). Requiring medical directors to hold current and unrestricted medical licenses in the state in which the health plan enrollee resides gives the state medical board the authority and jurisdiction to investigate complaints arising from medical precertification decisions made by MCO medical directors.

An MCO has the right to terminate a provider's contract based on quality of care issues, thus protecting its enrollees from an incompetent physician. But unless the state medical board is notified of this action, that

physician is free to practice medicine, unrestricted, on patients in other networks and other communities, potentially jeopardizing the health and well-being of the public.

State medical boards are charged with protecting the public from the unprofessional, improper, incompetent, unlawful, fraudulent and deceptive practice of medicine. The Federation, through the work of this committee and through future initiatives, intends to seek common ground with managed care providers and their regulatory bodies, and identify opportunities to collaboratively ensure that managed care enrollees have access to competent, qualified physicians.

Section V. Glossary

The committee identified the following definitions as pertinent to its discussion of managed care.

- **Capitation (CAP).** A contractual arrangement whereby a stipulated dollar amount is established to pay for all health care services delivered to a plan member by a health care provider over a specified period of time.
- **Employee Retirement Income Security Act (ERISA).** A federally mandated plan to provide protection for the pension interests of employees. (ERISA preempts restrictive state health insurance laws insofar as they attempt to regulate self-funded employee plans, though courts have held that they can be applied to insurers.)
- **Financial.** Mechanism through which physicians receive payments.
- **Incentives.** To reward behavior impacting utilization of medical services.
- **Gag Clause.** A provision in a managed care contract which prohibits a physician from discussing with a patient a potential diagnosis or therapeutic option if such is not covered by the patient's benefit plan.
- **Health Maintenance Organization (HMO).** A company (comprehensive health service organization) or set of related entities organized to provide health benefits to an enrolled population, for a predetermined fixed periodic amount paid by the purchaser (government, employer or individual). Other than emergency services, neither enrollees nor providers receive payment for services obtained or provided outside the network. There are three general types of HMOs:
 1. **Staff Model.** Physicians providing care in this model are salaried by the company which owns the HMO. These physicians usually limit their practices to subscribers of the HMO. Typically, the hospitals also are owned by the HMO, but some services may be contracted to selected hospitals. One example is Kaiser Permanente.
 2. **Medical Group Model.** Physicians providing care under this model are in large multispecialty or primary care medical groups which contract with the HMO. These physicians usually draw the majority of their income from the HMO subscribers. Typically, the HMO contracts with hospitals as needed, but can own hospitals, e.g., FHP, Inc., and Mullikin Medical Systems.
 3. **Independent Practice Association Model.** In this model, physicians providing care are organized in IPAs, which contract with the HMO. These physicians generally receive a smaller portion of their income from several different HMOs, as well as indemnity subscribers. Typically, the HMO contracts with hospitals, as needed. Generally, Staff Model HMOs have the lowest cost structures and IPAs have the highest cost structures.

- Health Plan Employer Data and Information Set (HEDIS). Standardized performance measures, including both reporting and testing measures, designed to assure that purchasers and consumers have the information they need to reliably compare the performance of managed care organizations.
- Independent Practice Association (IPA). A legal entity comprised of practicing physicians who, while maintaining private practices, agree to work together for common managed care business purposes, usually capitated contracts. Typically, the IPA's Board of Directors is authorized to negotiate with payors for total physician payment and empowered by participating physicians to determine methods and amounts of payment to physicians for professional services. Often formed for purposes of managed care capitated contracts, IPAs are capable of participating in any form of managed care.
- Integrated Health Care Delivery System (IDS). A term which describes the aggregation of the complete spectrum of health care providers and organizations necessary to meet the health care needs of a defined patient population, for a predetermined payment under a range of managed care payment vehicles with various insurance companies. Included in a single IDS may be primary care physicians, specialists organized in some type of physician organization for managed care, an acute care hospital, rehabilitation services and facilities, long-term care facilities, home health care services and hospice services. The nature and extent of the relationships can range from contractual agreements among the participants and joint ownership of segments of the IDS, to a single corporate entity.
- Managed Care. A system of managing and financing health care delivery that seeks to ensure services provided to managed care plan members are necessary, efficiently provided and appropriately priced. Through a variety of techniques, such as preadmission certification, concurrent review, financial incentives or penalties, managed care attempts to control access to provider sites where services are received, contain costs, manage utilization of services and resources, and ensure favorable patient outcomes.
- Medical Necessity. Those covered services required to preserve and improve the health status of a plan member in accordance with the accepted standards of medical practice by the medical community in the area where services are rendered.
- National Committee for Quality Assurance (NCQA). An independent not-for-profit organization nationally recognized as the leader in the effort to measure, assess, accredit and report on the quality of care provided by the nation's MCOs.
- Patient Advocate. Individual who pleads or argues in favor of a cause, idea or benefit in relation to a patient. This is considered a fundamental duty inherent in the physician-patient relationship.
- Physician Hospital Organization (PHO). In the managed care context, a business entity formed by a defined group of physicians and a hospital for managed care contracting.
 - Examples of PHO relationships include a partnership model and a parent subsidiary model in which the hospital or the physician organization is the parent. Such organizations also may engage in non-managed care health-related activity such as ownership of facilities, home health services, etc.
 - Preferred Provider Arrangement (PPA). An arrangement where a third party payor contracts with a group of medical providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

- Preferred Provider Organization (PPO). A network of hospitals, doctors or both who have agreed to a reduced fee in return for varying degrees of limitation on the number of participating providers. Conceptually, the greater the discount the smaller the network, so that participating providers are guaranteed higher volumes of patients. PPO health plans usually require an enrollee to pay a higher copayment for using non-PPO providers.

Epilogue

A draft of this report was circulated to all state medical boards and was presented to a meeting of executive directors of state medical boards. The committee is grateful to those who provided comments. Many of their suggestions have been incorporated into the final report.

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