REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH ON

THE ROLE OF THE COMMONWEALTH IN MONITORING AND IMPROVING THE QUALITY OF CARE IN MANAGED CARE PLANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Department of Health

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TO: The General Assembly of Virginia

The Report contained herein is pursuant to House Bill 2785, agreed to by the 1997 General Assembly.

This report constitutes the response of the Commissioner of the Virginia Department of Health to the request to study the role of the Commonwealth in monitoring and improving the quality of care in managed care plans.

Respectfully Submitted,

Randolph L. Gordon, M.D., MPH
State Health Commissioner

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TO THE JOINT COMMISSION ON HEALTH CARE

VDH VIRGINIA DEPARTMENT OF HEALTH

Protecting You and Your Environment

COMMONWEALTH OF VIRGINIA
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APPENDICES

List of Abbreviations

AAHCC	American Accrediation Health Care Commission
AAPI	American Accrediation Program, Inc.
AMHO	Association of Managed Healthcare Organizations
ASO	Administrative services only
BOH	Board of Health
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DHES	Department of Health Evaluation Science, University of Virginia
DHP	Department of Health Professions
DMAS	Department of Medical Assistance Services
DOL	Department of Labor, U.S.
EOC	Evidence of Coverage
ERISA	Employee Retirement Income Security Act
HB 2785	House Bill 2785
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data Information Set
HJR 611	House Joint Resolution 611
HMO	Health Maintenance Organization
IOM	Institute of Medicine
JCHC	Joint Commission on Health Care
MOA	Memorandum of Agreement
MCO	Managed care organization
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NGA	National Governors' Association
PCP	Primary care providers
POS	Point of Service
PPO	Preferred provider organization
PRO	Peer Review Organization
QA	Quality Assurance
SIR	Southern Institute of Research, Inc.
SJR 67	Senate Joint Resolution 67
TPA	Third party administrator
UM	Utilization management
UR	Utilization review
URAC	Utilization Review Accrediation Council
UVA	University of Virginia
VDH	Virginia Department of Health
VHI	Virginia Health Information, Inc.

I. EXECUTIVE SUMMARY

Rapid shifts in the health care market have led consumers to demand assurances that the quality of care delivered and the level of protections afforded to them be optimized in Health Maintenance Organizations (HMOs) and other forms of managed care. During the past few years in particular, states have enacted many laws intended to address managed care limits on access to providers and services. However, regardless of the content and scope of new legislation, consumer protections depend on an impartial authority that can validate compliance with the law. The traditional regulation of insurance through the State Corporation Commission's Bureau of Insurance (BOI) was intended to address issues such as licensure, solvency, trade practices, and conduct in the marketplace. HMOs and other forms of managed care provide more than health insurance; they also provide a delivery system for care, and the BOI recognized the necessity for an expanded scope of oversight to address medical and clinical issues. Until very recently the Virginia Department of Health (VDH) has not been active in assuring the quality of care in HMOs, and it has never had authority to conduct quality of care examinations in other forms of managed care organizations (MCOs).

The 1997 General Assembly took a comprehensive approach to quality protections and passed House Bill 2785 (HB 2785, Appendix A), which required that the State Health Commissioner examine the quality of care plans and enrollee complaint systems of HMOs. In addition, it directed the State Health Commissioner to study the quality of health care services delivered in HMOs and other MCOs and recommend the "appropriate role of the Commonwealth in monitoring and improving the quality of care in managed care plans . . . ." The following report reviews and analyzes selected federal and state statutes and regulations governing quality of care and grievance protections for Virginians in managed care plans. While it focuses on HMOs, this report also explores other forms of managed care, such as preferred provider organizations (PPOs).

In an attempt to involve all parties affected by this review, a study group was formed consisting of relevant state agencies,[1] consumers and representatives from the health care industry.[2] The study group addressed several questions. First, what is the current role of the Commonwealth in monitoring and improving the quality of care in HMOs and other forms of managed care? Second, what private sector activities are currently being undertaken to assure high quality of care in HMOs and other forms of managed care? Third, how adequate are the current public and private mechanisms to assure high quality in MCOs? Fourth, should all managed care entities be

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[1]Departments of Health Professions, Medical Assistance Services, and Health, and the Bureau of Insurance.

[2]Virginia Hospital and Healthcare Association, Virginia Association of HMOs, Medical Society of Virginia, Virginians for Patient Choice, and Virginia Chamber of Commerce.

held accountable for quality of care protections? Fifth, what is the appropriate role of the Commonwealth in monitoring and improving quality of care in managed care organizations?

More than a dozen separate analyses were undertaken to provide responses to the study questions, involving standard research methods such as statutory analyses, interviews, focus groups, surveys, and selective literature reviews. VDH contracted with the University of Virginia, Department of Health Evaluation Sciences (UVA/DHES) to conduct objective research to supplement the analyses developed by VDH. In particular, UVA reviewed the current quality assurance plans and complaint procedures in managed care plans. UVA also worked with The Southeastern Institute of Research, Inc. (SIR) to conduct a random survey of Virginians to determine consumers' awareness of their rights and responsibilities regarding complaint procedures for their health plan.

The working definition of quality used by the Study Group was adopted from Virginia's health facilities regulatory program. Specifically it derives from the definition contained in the *State Medical Facilities Plan* (12VAC5-230). The scope of the definition applies to seven components of quality recognized by the health care industry as appropriate areas for state oversight during a Round Table on *The Quality of Care in Network-Based Health Delivery Systems* convened by the State Health Commissioner in August 1996. These "consensus" components are: (1) complaint resolution and consumer satisfaction; (2) access and availability; (3) prevention; (4) credentialing; (5) consumer/provider education and awareness; (6) outcome measures and accountability; and (7) improvement of community health. These "consensus" components are the focus for analysis in this report. This review assesses whether the Commonwealth has sufficient authority for monitoring and improving the managed care health plans' policies, procedures, and programs affecting these components of quality. However, there are unresolved issues about the definition and the meaning of the "consensus" components.

Consumers should have a realistic understanding about the number of Virginians who will benefit from enhanced protections and of the level of quality that the Commonwealth can assure them. Consumers need to take prudent steps to educate themselves about their rights and responsibilities. There are several important reasons why this is so:

- State oversight of quality is limited to about 25 percent of the population in Virginia. Federal laws governing Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and most important, a large portion of employer-sponsored health benefit plans, limit actions that the Commonwealth can take.

- ERISA (Employee Retirement Income Security Act of 1974) health plans that are self-funded by employers are exempt from state oversight and regulation. Thus, state statutes and regulations addressing managed care protections will not affect individuals in ERISA plans. The Joint Commission on Health Care (JCHC) has estimated that one third of privately insured individuals are covered by ERISA self-funded plans.

- Ideally, the public and private sectors will work together to assure high quality of care in the market. Current laws do not appear to provide adequately for oversight of quality, but it is important that the Commonwealth balance the legitimate demand for choice, access, and quality with the need to encourage innovation and cost containment by insurers.

Although the current laws appear to address many of the appropriate areas of quality, this report concludes that there are deficiencies in the laws and regulations that need the attention of the General Assembly. The Commonwealth currently has inadequate oversight mechanisms to determine whether health plans are performing in accordance with defined statutes and regulations or with standards these health plans set for themselves. This report concentrates principally on improving current law governing systems-level safeguards. The three general areas that relate to the components of quality and are targeted for improvements include: (1) quality of care assurance/monitoring and improvement, (2) consumer awareness and education, and (3) complaint resolution. The most significant findings of this report are as follows:

- Oversight laws have until recently focused on HMOs without including other forms of managed care. It is important that all Virginians enrolled in managed care have the same level of protection. State oversight should be extended on the basis of the functions performed by all insurers.

- The *Code of Virginia* requires the State Health Commissioner to examine quality assurance and enrollee complaint systems developed by HMOs, but does not provide adequate authority to address deficiencies. The current Memorandum of Agreement (MOA) between the BOI and the VDH cannot resolve this limitation. The authority granted to the BOI is insufficient to address problems of quality.

- More can be done to educate consumers about their health insurance plans. Insurers, providers, consumer groups, patient advocates and purchasers need to develop innovative private-sector methods to educate their constituencies about the existing protections and how they can benefit from them. VDH can assume an educational role limited to assisting and guiding enrollees confused about how to "navigate" themselves through the internal complaint process of their health plan. Finally, providing more information to enrollees about utilization appeals at the time of denial of care and/or through other subscriber communications could be a useful means of educating policy holders.

- Chapter 54 of Title 38.2 of the *Code of Virginia* (Chapter 54) contains requirements for a particular type of grievance protection relating to an insurance company's utilization review (UR) or medical necessity decisions. The latter type of grievance is perhaps the most important protection for providers and patients in managed care plans. The BOI lacks regulatory authority for this oversight function, as well as the medical expertise to carry it out. The report presents a possible role for VDH with regard to the regulatory oversight of Chapter 54 appeals.

- Private sector initiatives to assure quality have had a significant impact on HMOs. Employers' interest in quality of managed care has given impetus to the development of accreditation standards and outcome measures for managed care plans. However, national trends suggest that, for employers, quality is a consideration secondary to cost. Private accreditation organizations recommend against states substituting private accreditation of health plans for state oversight obligations; nevertheless, opportunities exist to integrate private accreditation into state oversight of managed care.

II. BACKGROUND

A. Authority for Study

HB 2785 of the 1997 Session of the General Assembly, in its second enactment, directed the State Health Commissioner, in cooperation with the BOI, the Department of Health Professions (DHP), and other state agencies, to study the quality of health care services provided by HMOs. The legislative directive explicitly required that the study: examine quality of care mechanisms currently in place for HMOs and assess the sufficiency of those mechanisms; address to what degree quality mechanisms are in place for other forms of managed care; and consider coordination of the regulatory roles of VDH and BOI, and the appropriate role of VDH and other state agencies in monitoring quality in HMOs. Additional study directives concern HMO complaint systems and whether they should include provisions for provider concerns; whether there is a need for a mechanism for adjudicating controversies or a need for an independent appeals/ombudsman program; and the Commonwealth's role in providing consumer information on managed care issues. (A copy of HB 2785 is provided at Appendix A).

B. Recent History of Quality-Related Managed Care Legislation

Enrollment in HMOs in Virginia has increased rapidly since the late 1980's. The most recent estimate of the Virginia Association of HMOs puts the number of enrollees at 1.38 million. While this number includes enrollees in employer-funded plans that are exempt from state regulation under ERISA, there remain a significant number of Virginians in HMO plans that are regulated by the BOI of the State Corporation Commission.

The first legislation specific to managed care in Virginia was the HMO Act of 1980, incorporated into the *Code of Virginia* as Chapter 43 of Title 38.2. These statutes address licensure and operating requirements for HMOs and the role of the BOI in regulating them.

Since 1995, the Virginia General Assembly has passed the following legislation aimed at protecting consumers and providers in managed care plans:

- Chapter 54 was added to Title 38.2 in 1995. These statutes contain requirements for utilization management (UM) and appeals of Utilization Review (UR) decisions made by any health insurer.

- Chapter 43 of Title 38.2 was amended in 1994 and revised in 1995 to provide for "freedom of choice" of pharmacies in HMOs; this chapter provides for the inclusion of any pharmacy in an HMO network if the pharmacy agrees to accept the HMO's reimbursement (§38.2-4312.1).

- Act of the Assembly, Chapter 776 (House Bill 1393 which passed in 1996), provides for the following: continuity of care for patients whose providers were terminated by a managed care plan; disclosure to purchasers of all reimbursement mechanisms including those that give providers incentives to control utilization of services; and that contracts between managed care plans and providers permit and require the provider to discuss all treatment options with their patients. This legislation also offers provider protections in provisions for disclosure of network development and the terms for inclusion in the network; prohibits "gag orders"; and prohibits contract provisions waiving the provider's right to seek legal redress or requiring a provider to indemnify the MCO for its negligence (§38.2-3407.10).

- The definitions section of Chapter 43 of Title 38.2 was expanded in 1995 to include emergency services, which are defined as health care sought in response to symptoms of sufficient severity that a prudent lay person could reasonably expect impairment, dysfunction, or harm to his mental or physical health in the absence of treatment (§38.2-4300).

- In 1996, Title 38.2 was amended to include a provision requiring health insurers to permit women direct access to obstetricians/gynecologists without preauthorization for routine services attendant to an annual examination (§38.2-3407.11).

- Also in 1996, Title 38.2 was amended to require health insurers to provide post-partum services to mothers and newborns in accordance with criteria of the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics (§38.2-3414.1).

- In 1997, the General Assembly passed House Bill 2062, requiring HMOs to provide their members 24-hour emergency access to services or to a licensed medical professional by telephone. The legislation requires HMOs to pay for medical screening and stabilization if a representative of the HMO refers a member for emergency services or if the HMO does not have a system for 24-hour access.

The legislation listed above has been enacted; a number of other bills addressing quality of managed care have been introduced in the last three sessions of the General Assembly.

C. 1997 Studies Concerning Quality in Managed Care

In addition to HB 2785, there are currently other studies under way mandated by the General Assembly that address quality in managed care plans:

- Senate Joint Resolution 297 and House Joint Resolution 631 establish a task force to study point-of-service (POS) options for HMO plans. POS options allow HMO members, for additional out-of-pocket costs, to go to out-of-network providers without a primary care provider's referral.

- HJR 611 requires the BOI, in cooperation with the VDH, to examine statutes and regulations governing HMOs to determine whether their provisions should apply to other forms of managed care plans.

- Section 54.1-2409.2 of the Code of Virginia directs the Department of Health Professions (DHP) to prepare a report on the appropriate criteria to be used in determining the need for regulation of any health care occupation or profession. The statute directs DHP to examine the current health care delivery system, the current and changing nature of health care settings, and the interaction of the regulation of health professionals with a number of other areas of regulation.

- In 1996, pursuant to Senate Joint Resolution 67 (SJR 67), the JCHC issued a report on its study of the appropriate role of the agencies of the Commonwealth in overseeing the managed care industry. Three of the options presented in this study were enacted into legislation: (1) the Health Commissioner's role of reviewing HMO quality and HMO complaint systems was changed from discretionary to mandatory by changing the word "may" to "shall" in § 38.2-4315(B) and §38.2-4308(C) of the *Code of Virginia*; (2) the Health Commissioner was requested to report the results and recommendations of VDH's evaluation of its role in overseeing the quality of health care services provided by HMOs to the Joint Commission and the General Assembly; and (3) examination of the need for an independent appeals/ombudsman mechanism for managed care consumers. HB 2785 encompasses all three of these options from the Joint Commission report.

Recent legislative activity in the General Assembly indicates a growing demand among the public at large for state oversight of the quality of care delivered in managed care plans.

D. Roles of the Virginia Department of Health

Although the Health Commissioner has had permissive authority to examine the quality of health care services and the complaint systems of HMOs (§38.2-4307; §4307.B.4; §4308; §4308.B; §4315.B,§ 4316), this prerogative was not exercised until recently.

In August of 1996, VDH convened a round table discussion among stakeholders in the managed care industry in Virginia: providers, advocates and lobbyists, HMOs, and regulators. The focus of the discussion was quality assurance in managed care. The group agreed on seven components of quality, and these components became the organizing principle for the study required in HB 2785 (see below, p. 11).

Shortly thereafter, VDH entered into discussions with BOI in order to properly define and coordinate the role of VDH with respect to BOI's regulatory oversight of HMOs. The result of this collaboration was a MOA between the two agencies that formalizes VDH's participation in monitoring and ensuring quality in HMO plans.

In the 1997 session of the General Assembly, HB 2785 was introduced and passed both chambers with no dissenting votes. The bill changed the Health Commissioner's role from discretionary to mandatory by changing the word "may" to "shall" in §38.2-4308.C. and §38.2-4315(B) with respect to the Commissioner's review of HMO complaint systems and examination of the quality of HMO health services. VDH is additionally charged with receiving and responding to quality of care complaints from managed care enrollees. The bill also required that the Health Commissioner direct an ambitious study assessing the sufficiency of current managed care protections in law and private sector initiatives.

III. METHODS

A. The Process

In order to address the HB 2785 study requirements, a study group was formed representing various state agencies, the health care industry and consumers. Agencies were required to participate in order to provide expertise relative to their particular areas of responsibility. The invitation to private sector representatives was based on their involvement in developing the legislation, the effect that the legislation had on the members of their organizations, or both. Members of the Study Group included the following:

Private Sector

The Virginia Association of Health Maintenance Organizations
The Virginia Hospital and Healthcare Association
Virginians for Patients' Choice
The Medical Society of Virginia
The Virginia Chamber of Commerce

State Agencies

The Department of Medical Assistance Services
The Department of Health Professions
The Virginia Department of Health
The Bureau of Insurance, State Corporation Commission

availability of services, and making recommendations for improvements. The Commission is broadly represented by consumers, business, labor, health care providers, insurers, and experts on health care quality and financing. Its first task is to develop a "Consumer Bill of Rights" to ensure that patients have adequate appeals and grievance processes. In addition, the Commission will review legislative initiatives pertaining to quality and consumer protection.

As the study directive in HB 2785 requires an examination of state oversight of managed care, it would be beyond the scope of this study to analyze federal quality and grievance protections in detail. Considerations regarding the state regulation of managed care do not apply to all managed care plans in Virginia. Self-funded employee welfare benefit plans (29 *United States Code*, §1002(1)) are exempt from state insurance laws pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA)(29 USC §1144). In addition, federal and state benefit programs such as Medicare and Medicaid may also be exempt from some or all state regulation. As a result, state regulation of managed care principally affects the commercial market only, which represents approximately 25 percent of the overall health care market in Virginia, according to an estimate made by the JCHC. The following is a review of significant points about federal oversight of managed care:

A. ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) contains the requirements for health plans funded by private employers. This legislation affects all private sector group health plans, not just the plans that are "self insured." ERISA preempts state laws that "relate to" employee benefits plans (29 USC §1144(a)(1988)); however, state laws regulating the business of insurance are not preempted through ERISA's "savings clause." The courts have interpreted these two clauses to mean that states cannot regulate employee benefits directly, but can regulate the insurers that contract with employers. This distinction between commercially insured and employer self-funded health plans was made by the United States Supreme Court in *Metropolitan Life Insurance Company v. Massachusetts.* The Court held that the state could mandate which benefits a health insurance company had to offer, but could not mandate benefits for self-insured plans.

For the purposes of the HB 2785 study, the most significant point about self-funded plans is that they cover the largest number of insured Virginians, 35% of the population, according to the estimates by the Joint Commission. Beneficiaries of these plans are not entitled to the state oversight protections discussed in this report.

The U.S. Department of Labor (DOL) administers ERISA in accordance with federal regulations at 29 CFR §2510.3-1-2500.408b-2. There are no mandated benefits for ERISA plans; employers may choose which health care services will be offered. It is required that participants and beneficiaries be informed about the extent of their benefits and their rights under the plan. They must also be informed of procedures for filing claims, the basis for claim denials, and procedures for appealing denials.

The DOL will take action on problems that affect the entire membership of a self-insured plan, but does not get involved in conflicts concerning benefits between an individual and a plan. DOL's assistance to individuals is primarily in the form of information about their rights under ERISA. Beneficiaries of employer-funded health plans may take their disputes to federal court, but can only collect the cost of a denied benefit, and, in some cases, attorneys' fees.

Because of the minimum standards imposed by ERISA and the preemption of state regulations, consumers in employer-funded health plans may have fewer protections than Virginians in commercially insured plans (Appendix H, p.8-11).

B. Medicare

The Code of Federal Regulations (CFR) provides for enrollment of Medicare beneficiaries in HMOs, Competitive Medical Plans, and Health Care Prepayment Plans. In Virginia there are approximately 10,105 Medicare beneficiaries in HMO plans according to a 1997 estimate of the Virginia Association of HMOs. Part 417 of 42 CFR details the many requirements for health plans seeking contracts for Medicare beneficiaries. A quality assurance program is required at 42 CFR §417.106 that includes a focus on "state of the art" health outcomes; requirements for accessibility and continuity of care; and collection of data on performance and patient results.

The Health Care Financing Administration (HCFA), the federal agency with regulatory oversight of the Medicare program, requires states to contract with Peer Review Organizations (PRO) that perform mandated reviews of all beneficiary complaints concerning quality of care. The PROs have the authority to recommend sanctions through HCFA. The PRO must also review any decision by a hospital or managed care plan to terminate services where the beneficiary would be liable for the cost of the care. Any other medical necessity determinations are reviewed by the Center for Dispute Resolution, another independent review organization.

Medicare beneficiaries also have the right of independent appeals and grievances. If the dispute involves an amount of $100 or more, the beneficiary has the right to a hearing by an administrative law judge; if the amount in controversy exceeds $1,000, the beneficiary is entitled to judicial review of the hearing. Grievance and appeal rights are set forth in §1869 of the Social Security Act and in CFR, §417.600 - §417.694. (Appendix H, p. 39)

C. Medicaid

HMOs that enroll Medicaid beneficiaries in Virginia are regulated by the Department of Medical Assistance Services (DMAS) and HCFA in addition to the State Corporation Commission's BOI. The CFR requires that HMO contracts contain provisions specifying that the Medicaid agency evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract, and that contracts require HMO participation in an annual independent external review of the quality of services furnished under the contract(42 CFR §434.6(a)(5), §1902(a)(30)(C) of the Social Security Act). In addition, 42 CFR §434.34 requires

that HMOs contracts provide for: "an internal quality assurance system that is consistent with the utilization control requirement of part 456 of CFR; provides for review by appropriate health professionals of the procedures followed in providing health services; provides for systematic data collection of performance and patient results; provides for interpretation of these data to the practitioners; and provides for making needed changes." 42 CFR at §434.53 assigns to the Medicaid agency the responsibility of periodic medical audits, at least annually, and the collection of data that includes reasons for enrollment, disenrollment, termination and use of services. The state Medicaid Manual and §1902 (a) (30)(C) of the Social Security Act specify the types of entities eligible to perform external review.

Medicaid recipients are entitled to a formal independent appeal process. Beneficiaries enrolled in HMOs may use their HMO's grievance procedure but may appeal directly to DMAS if they choose. A formal grievance is required to be initiated in writing. Should the grievance proceed to a hearing, the decision will be rendered by a DMAS hearing officer and will be binding. Medicaid grievance rights and procedures are found at 42 CFR §431.200 - §431.246.

V. WHAT IS THE CURRENT ROLE OF THE COMMONWEALTH IN MONITORING AND IMPROVING THE QUALITY OF CARE IN HMOS AND OTHER FORMS OF MANAGED CARE?

There are several agencies involved with the oversight of the quality of care provided by MCOs. The DHP is responsible for the licensing of practitioners that may have contracts with MCOs. It also receives and investigates complaints on practitioners regulated by the respective professional boards (Appendix H, p. 31). In addition, the BOI and the VDH have oversight responsibilities affecting the plans. Their roles are briefly discussed below. (Appendix H also examines their roles with respect to complaints and grievances.)

A. State Agencies with Oversight of HMOs

1. The Bureau of Insurance (BOI)

The BOI of the State Corporation Commission is the primary agency involved in regulatory oversight of managed care, responsible for licensure and compliance with state laws for all companies in the business of insurance in the Commonwealth. As provided by statute, the BOI initiates financial and market conduct examinations of all domestic health insurers at least every five years, focusing on financial solvency; marketing, sales and claims practices; business practices; and the systems in place for regulatory and statutory compliance. An important quality aspect of the market conduct examination is the review of complaint records maintained by the insurance company and a comparison of these records to the BOI's internal records of complaints brought to the Bureau by consumers.

In addition to financial and market conduct examinations, the BOI also targets investigations of insurance companies where there is indication of noncompliance with applicable law. For example, the BOI's Life and Health Consumer Services Section investigates complaints about insurance companies brought by individual consumers. While the BOI advocates on behalf of a consumer and provides information relevant tocomplaint resolution, it does not adjudicate individual complaints. If the BOI finds a violation of a law, it may require remedy to individuals as part of its settlement with the insurance company. In this way, the BOI functions similarly to an ombudsman; however the BOI does not have the authority to adjudicate disputes concerning an insurer's contractual obligations or UR decisions.

The BOI requires that health insurance carriers keep records of complaints for three years or since the date of their last market conduct examination, whichever is the more recent time period. The record must indicate the classification of complaints by line of business, the nature and disposition of each complaint, and the time it took to process each complaint.

With respect to HMOs and other forms of managed care, the most substantial difference in oversight activities of the BOI concerns initial licensure, for which HMOs have requirements in addition to those of other insurance carriers. These additional requirements reflect the fact that HMOs provide a delivery system for care in addition to reimbursement for care. Most significant are the requirements for complaint procedures, QA plans and provider networks. The BOI must ensure the adequacy of the HMO's provisions for these aspects of health care delivery. HMOs are also required to provide annual complaint reports to the BOI. The report must include a description of the complaint system procedures; the total number of complaints processed through the system; a compilation of causes for the complaints; and an accounting of the malpractice claims settled or adjudicated during the year by the HMO and any of its health care providers.

2. The Virginia Department of Health (VDH)

The VDH has no statutory or regulatory authority over health insurance companies that are not licensed as HMOs. It has only very recently become involved in HMO oversight, chiefly through the execution of the MOA signed by the BOI and VDH in January of 1997(Appendix N).

The MOA between VDH and BOI is prefaced by reference to the Health Commissioner's statutory authority in Chapter 43 to examine the quality of health care services and complaint systems of HMOs. The agreement provides that VDH will assist the Bureau by on-site and administrative review of QA issues; that VDH will participate in market conduct examinations; and that the Bureau will provide advice and expertise as requested. The MOA requires that VDH review and approve HMO complaint systems for licensure and that VDH monitor and report HMO providers who are not in compliance with licensure regulations addressing quality of care. VDH is also required to review HMO QA and UR programs both as part of licensure and as needed, and to review HMO network adequacy. VDH responsibility for on-site reviews

encompasses the grievance and complaint systems, the QA program, and the medical delivery system.

Prior to the effective date of HB 2785, the VDH had been conducting quality complaint investigations about HMOs under the MOA. Subsequent to its enactment, the VDH is receiving and responding to quality of care complaints from managed care enrollees as directed by the mandate. Complaints about all MCOs are referred to VDH from the BOI in accordance with a detailed protocol for developed as part of this study by the VDH's Center for Quality Health Care and Consumer Protection (Appendix J).

Finally, with the passage of House Bill 1307 in the 1996 General Assembly, the oversight for health care data reporting has recently become a responsibility for the VDH (Chapter 7.2 of Title 32.1). The VDH exercises that responsibility through its health data reporting contractor, the Virginia Health Information, Inc. (VHI). The VHI is a nonprofit, tax-exempt health data organization that develops and implements health data projects that provide useful information to consumers and purchasers. Data initiatives, such as publication of consumer satisfaction reports using Health Plan Employer Data Information Set (HEDIS), are presented in its 1997 *Strategic Plan.* Unlike the health data reporting requirements imposed on hospitals and nursing homes, the HEDIS data initiative is voluntary.

B. State Laws and Regulations Providing Quality and Grievance Protections

In order to describe the Commonwealth's role in monitoring and improving the quality of care in HMOs and other forms of managed care, it is helpful to use the consensus components of quality adopted by the Study Group. These components are: (1) complaint resolution and consumer satisfaction; (2) access, availability, and continuity; (3) prevention; (4) credentialing; (5) consumer/provider education and awareness; (6) outcome measures and accountability; and (7) improvement of community health. (See Appendix I for a detailed description of the statutes and regulations addressing quality of care.). This section begins with a discussion of quality in general, followed by an examination of six of the seven components of quality.

1. Quality in General

Requirements for a QA plan or program are unique to HMOs in Virginia statutes and regulations; there are no similar requirements for other insurance entities. The State Health Commissioner is required to examine the quality of health care services of all HMOs licensed in the Commonwealth and the providers with whom they contract as often as considered necessary for the protection of the citizens of the Commonwealth. The Health Commissioner is also given the authority to certify to the State Corporation Commission (SCC) that an HMO cannot provide quality health services.

The *Code of Virginia* and *the Virginia Administrative Code* contain the same language regarding the HMO's QA plan. No specific requirements are necessary in the plan, only that the HMO has a plan that provides for adequate resources and assessment of the quality of care.

2. Complaint Resolution and Consumer Satisfaction

The enactment clause of HB 2785 contains a provision requiring the VDH "to receive and respond to" complaints from managed care plan enrollees regarding quality of care issues. This is the only statutory language that differentiates a quality of care complaint from any other type of complaint and the only statutory language expanding the Health Commissioner's purview from HMOs to other forms of managed care.

HMOs are required to have an enrollee complaint system and to submit annual complaint reports. The complaint system must be approved by the State Health Commissioner and the BOI. Administrative law further details the requirements for the complaint system, including the requirement that grievances be resolved in 180 days. The importance of the complaint system is reflected in the statutory provision for suspension of licensure if the HMO fails to implement a complaint system in accordance with the requirements of Chapter 43 of Title 38.2.

There are no statutes or regulations requiring that health insurers other than HMOs have grievance systems or procedures. All insurance companies are required to maintain complete records of all complaints since the last market conduct examination or for the last three years, whichever is the more recent time period. A "complaint" for commercial carriers is defined as any written communication expressing a grievance.[5]

Chapter 54 of Title 38.2 (Chapter 54)[6] applies to all health insurers that perform UR, which is the determination of whether covered services are medically necessary. Chapter 54 provides for the patient's provider to appeal UR decisions, and thus, addresses one of the most important aspects of complaint resolution for consumers in managed care plans. Except for expedited appeals, Chapter 54 requires that final appeals of UR decisions be made by a peer of the treating physician who is not employed by or a director of the insurance entity, and who was not previously involved in the UR decision at issue. The physician peer is required to be board certified or board eligible in a specialty pertinent t the issue under appeal.

Concerning consumer satisfaction, statutory requirements limited to HMOs require allowing covered persons their choice of primary care providers (PCPs) and require mechanisms permitting consumer participation in policy and operations.

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[5] Regulations for the Medallion II managed care programs contain definitions of "appeal" and "grievance", but do not define "complaint" (12VAC 30-120-360)

[6] Chapter 54 does not apply to Medicare, Medicaid, and CHAMPUS.

3. Access, Availability, and Continuity

HMOs are required to file contracts and provider lists with the Bureau, as a condition of licensure. This enables the Bureau to assess the accessibility, and to some degree, the adequacy of the network. The *Code* further requires that the list of providers with whom the HMO has contracts be updated quarterly and filed with the Bureau. The regulations define standards for access to care and there are several HMO statutes that specifically address access to emergency services.

All health insurers have a number of requirements imposed on them addressing access to specific providers, such as pharmacies, podiatrists, and obstetricians and gynecologists, and all are bound by the same length of stay requirements for maternity care. The "Patient Protection Act" (*Code*, §38.2-3407.10), which makes provisions for continuity of care and requires disclosure of treatment options and disclosure of provider panels, likewise applies to all health insurers.

4. Prevention

In statute, HMOs are required to provide preventive care services described in the definitions section of Chapter 43 of Title 38.2. For all other health insurers, the preventive services mandated include well-child care, mammograms and Pap tests. The most strenuous requirements for preventive services apply to the Essential Benefits Plan, and this is only applicable to the small group market (50 or fewer employees).

5. Credentialing

There are no statutes or regulations requiring HMOs or other insurance companies to credential their providers. The laws only stipulate which practitioners and facilities must be licensed by the state and provide for reporting of disciplinary actions taken against practitioners by certain health care institutions.

6. Consumer/Provider Education and Awareness

In regard to consumer awareness and disclosure requirements, there are many more legal requirements for HMOs than for other health insurers. HMOs have specific disclosure requirements for their EOC including covered services and limitations; limits on out-of-pocket payment by the consumer; grievance procedures; and participating providers.

All health insurers are required to disclose the UR process contained in Chapter 54. They are also required to notify purchasers of the payment mechanisms used for provider reimbursement. At least annually, all health insurers must provide purchasers with a list of the current providers contracted with the plan, indicating those who are not accepting new patients. All health insurers are required to disclose in their policies or contracts information on how to contact the BOI if they are unable to resolve their concerns with their insurance company or agent.

All health insurers are required to disclose in their policies or contracts information on how to contact the BOI if consumers are unable to resolve their concerns with their insurance company or agent.

7. Outcome measures and Accountability

There are no outcome measures or data required of HMOs only. The *Code of Virginia* makes provisions for health care data analysis and reporting in Chapter 7.2 of Title 32.1. This initiative is cited in the *Code* as "essential to the improvement of the quality and cost of health care in the Commonwealth," and delegates the responsibility of administration of this initiative to the State Board of Health (BOH) and the Health Commissioner. Because health insurance companies are included in the definition of "provider" for the purposes of this data initiative, this legislation does provide for voluntary reporting of outcome measures or data from all managed care entities; however, technical problems with the data sources will have to be resolved before consumer information on health plans is available through this source (Appendix O).

VI. WHAT PRIVATE SECTOR EFFORTS ARE CURRENTLY BEING UNDERTAKEN TO ASSURE HIGH QUALITY OF CARE IN HMOs AND OTHER FORMS OF MANAGED CARE?

This section describes private sector quality systems developed in response to employer concerns about the quality of managed care. These concerns precipitated the development of national accrediting organizations such as the National Committee for Quality Assurance (NCQA) and the AAHCC, who share the mission of assessing quality in managed care plans. This section also describes approaches to QA used by self-funded employers and integration of private and public sector quality oversight mechanisms. (Summary of NCQA & AAHCC's presentations to the Study Group are in Appendix J)

A. National Quality Accreditation Organizations

1. National Committee for Quality Assurance (NCQA)

The NCQA is a private, not-for-profit organization whose mission is to assess the quality of managed care plans. As of May 1996, NCQA had accredited 333 of the estimated 574 HMOs in the United States. According to the 1997 Directory of Virginia HMOs, six Virginia-licensed plans have full three-year NCQA accreditation, plans, eleven plans have provisional or one year accreditation, four plans are seeking or planning accreditation review, and eight plans have an unavailable status.

NCQA's purpose is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions. Their efforts are organized around two primary activities, accreditation and performance measurement, which are complementary strategies for

producing information to guide purchaser decision-making. NCQA began accrediting MCOs in 1991. Since then, they have expanded the range of organizations that they accredit to include managed behavioral health care organizations, credentials verification organizations and physician organizations.

For an organization to become accredited by NCQA, it must undergo a survey and meet certain standards designed to evaluate the health plan's clinical and administrative systems. In particular, NCQA's accreditation survey looks at a health plan's efforts to continuously improve the quality of care and service it delivers.

During an accreditation survey, plans are reviewed against more than 50 different standards, each of which focuses on an important aspect of health care delivery and consumer satisfaction. These standards fall into six broad categories: quality management and improvement; credentialing; member rights and responsibilities; prevention; UM; and medical records.

The standards are "state of the art," and accreditation is a rigorous process; a health plan must be aggressively managing quality to achieve full accreditation. As of April 30, 1997, approximately 53% of all HMOs in the nation were involved in the NCQA accreditation process. The NCQA reports that the base price is around $30,000 for a plan with 50,000 members.

NCQA produces Accreditation Summary Reports to further aid consumers and employers. These reports demonstrate a plan's degree of compliance with the standards in each of the six broad categories, and show how the plan performed compared to the national average.

Where accreditation standards are measures of the structure and processes an organization has adopted to ensure quality of care, the HEDIS is a measure of the outcomes of care. HEDIS are a set of standardized performance measures that assess effectiveness of care, accessibility and availability of care, member satisfaction, cost of care, health plan stability, informed choices, use of services, and plan descriptive information. NCQA uses these categories as part of a standard report card for managed care plans. (See Appendix P for a summary of accreditation organization standards)

2. American Accreditation Health Care Commission (AAHCC/URAC)

The organization was formally chartered February 14, 1990, as the Utilization Review Accreditation Commission, Inc., a 501© (3) not-for-profit corporation. It was specifically formed to develop national standards for the UR industry.

In 1995, URAC acquired the American Accreditation Program, Inc. (AAPI). AAPI had developed standards specifically aimed at the PPO industry and accredited a number of PPO programs in the early 1990s. URAC assimilated elements of the AAPI accreditation standards into its own network standards, which are generally applicable to the entire managed care industry, but are especially appropriate for evaluating PPOs and point of service (POS) plans.

In March 1997, URAC changed its corporate name to American Accreditation Health Care Commission, Inc. (AAHCC) to more accurately describe its expanding role as an accreditation company for a wide variety of MCOs. AAHCC currently offers programs in three areas: 1) provider networks and health plans; 2) UM; and 3) workers' compensation managed care. The network standards address provider network management and participation; quality management; UM; credentialing; and member participation and protection.

AAHCC original UR standards were revised in 1994 to provide a more stringent level for review and to address a broader range of issues and concerns. These standards address: program qualifications; quality improvement programs; confidentiality; staff qualifications and credentials; UR procedures; UM staff accessibility; on-site review procedures; information requirements; and appeals. AAHCC grants full accreditation for two years.

B. Self-funded Health Plan Initiatives

ERISA requires relatively few standards in the administration of self-funded health benefit plans. Administrators are held to fiduciary standards and required to administer the benefits according to the plan document. ERISA requires that plan beneficiaries be apprised of covered benefits, information about changes, eligibility requirements, the name of the organization administering the benefits, procedures for claims payments, and remedies available when claims are denied.

In spite of limited requirements under ERISA, many large and mid-size employers that self-fund their employee's health benefits are using their purchasing clout to choose health plans that are privately accredited. Employers typically contract for the services with a health plan that functions as a third party administrator (TPA). TPAs assume a range of administrative services including claims adjudication, customer service, UR, and provider network management. The employer may select the benefits to be offered or may select a plan currently marketed by the managed care entity. There are no coverage mandates under ERISA, so employers are free to offer their choice of benefits.

The employer's emphasis on quality is likewise discretionary. With respect to grievances, the employer may have human resources staff assigned to assisting employees with their benefits who can advocate on their behalf with the TPA. The final decisions on whether or not a service is to be covered will rest with the employer, although many employers will not get involved in these conflicts.

While actual numbers are not available for Virginia, a number of employers are interested in the quality of the managed care entity with which they contract for administrative services. Typically, the employers are interested in the provider network, particularly the accessibility to PCPs and hospitals. Employers may require separate customer service tracking systems for their employees and have specific standards regarding response time on the telephone. Accreditation by NCQA or similar organizations has increasingly come to be viewed as an imprimatur of

quality, and accreditation status may be an important consideration for a large employer contracting for Administrative Services Only (ASO) services. Included on NCQA's list of national companies requiring and requesting NCQA accreditation surveys are Allied Signal, Bristol Myers-Squibb, Chrysler, Digital Equipment, Ford, GE, IBM, Mobil, Nations Bank, PepsiCo, Procter & Gamble, UPS, and Xerox.

With the advent of HEDIS, employers have an even more specific measure of quality than accreditation status. Where accreditation examines a health plan's structures and systems, HEDIS measures the plan's performance, the results actually achieved by the plan. NCQA has developed a "Quality Compass © " to assist employers in choosing health plans on the basis of quality and value.

However, there are indications that for many employers quality is a secondary consideration to cost. The Wall Street Journal cited a KPMG Peat Marwick national survey indicating that "employers are giving a short shrift to widely touted attempts to measure the quality of health care plans." The survey reportedly revealed that employers are not paying much attention to attempts to measure the quality of MCOs and found that only 40% of employers rated NCQA accreditation as an important factor for choosing a health insurance plan (*Wall Street Journal,* 6/18/97). A national survey by the Washington Business Group on Health and Watson Wyatt Worldwide Consultants of 368 employers indicated that 53% of employers equate health care value with cost, but only 39% equate value with quality. This study also purportedly found that only 8% of the employers correlated value of a managed care plan to its accreditation status.[7]

C. Integration of Private Sector and Public Sector Standards

Because of ERISA's preemption of state laws, states and consumers have expressed concern about the ability of states to protect employees in self-insured plans. The federal DOL does not provide the level of individual complaint investigation typically provided by state insurance regulators. However, DOL has been seeking public comment on existing regulations on benefit claims procedures governing the health benefits of about 125 million Americans. Likewise, an NGA policy brief also calls upon the U.S. Congress to create new opportunities for states to assess the adequacy of consumer protections under ERISA. It proposes two options to address to accomplish this policy objective:

- Congress should work with the states to establish national health care standards for self-funded plans that are similar to those imposed by states on commercial plans. If Congress is unwilling to define legislative standards in ERISA, the U.S. DOL, in conjunction with the states, should be given the authority to develop and enforce regulations that, at the very least, establish essential consumer protections and remedies standards for self-funded plans.

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[7]*Managed Care Stats and Facts* (April 1, 1996)

- Anecdotal evidence suggests that consumer protection problems are more likely to arise in small self-funded plans. Congress could limit self-funding authority to businesses above a certain size. Businesses below that limit would be required to follow state laws. The U.S. DOL would need to enforce standards for those plans that remain under its jurisdiction (NGA, 1997).

Some states are attempting to work with employers and the federal government to investigate complaints in self-funded plans. For instance, Oklahoma and Maryland are currently working in partnership with the federal government to investigate consumer complaints in ERISA plans.

Currently, no states require NCQA accreditation for licensure. However, some states do require a quality review for licensure, which NCQA is licensed to perform. These states are Florida, Kansas, New Jersey, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and West Virginia. In about half of these states, regulators accompany the NCQA survey team. There is also a handful of states (Alabama, New York, Ohio, Tennessee, and Virginia) that require an MCO to have NCQA accreditation in order to have a contract with a state agency. There are no states that accept NCQA accreditation in lieu of licensure.

Another approach to integration of public and private standards is for states to incorporate NCQA or AAHCC standards into state licensure or certification procedures. Some states are using AAHCC accreditation status as an element of the regulatory process for HMOs, UR companies, and health insurers performing UR. Sixteen states and the District of Columbia recognize AAHCC/URAC standards and accreditation: Alabama, Arizona, Connecticut, District of Columbia, Georgia, Indiana, Iowa, Kansas, Maine, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, and Tennessee.

Although there are advantages to integrating private accreditation organizations into the state responsibility for oversight, neither NCQA nor AAHCC recommends that private accreditation be a substitute for state oversight. In an NCQA report (Winter 1995-96) entitled *States' Roles in Monitoring Quality Evolving*, Stephen Lamb, Assistant Vice President, set forth the position in this manner:

> There is an important distinction between requiring health plans to *undergo* an accreditation review, and requiring health plans to *pass* accreditation as a condition of licensure. With more than half the nation's HMOs still unsurveyed, NCQA opposes efforts to directly link a health plan's licensure status to the outcome of an accreditation review. Nor does NCQA advocate 'deemed status' in the traditional sense of a statutory requirement for regulators to accept evidence of particular accreditation body's decision as meeting state requirements. NCQA supports giving state officials the flexibility to approve, and periodically reevaluate, independent accreditation bodies to ensure coordination and consistency over time. Originally pioneered in Pennsylvania, this

approach has now been adopted by nearly every state incorporating private accreditation review processes into the HMO regulatory scheme.

Likewise, Guy D'Andrea, Director of Policy for AAHCC, stated that "final decisions about licensing or certification should be left to the state. This preserves both the integrity of the accreditation review process and the autonomy of the state."

VII. HOW ADEQUATE ARE THE CURRENT PUBLIC AND PRIVATE QUALITY OF CARE MECHANISMS TO ASSURE HIGH QUALITY OF CARE IN MANAGED CARE ORGANIZATIONS?

This section of the report analyzes the adequacy of the oversight for current quality of care mechanisms and is divided into four parts. The primary focus is on the oversight of processes and systems which commercial health plans use to assure and improve quality of care. The first part examines general provisions for quality and the sufficiency of the MOA between BOI and VDH to permit assessment of quality compliance. The second part analyzes the statutes and regulations addressing the components of quality. The third part examines the provisions of Chapter 54. These statutes address UR (medical necessity) determinations made by managed care companies and provide for appeals of those decisions. The special emphasis on Chapter 54 is due to the importance these statutes have for consumers whose insurers deny coverage for health care services that the treating practitioner believes are necessary. The fourth part addresses concerns expressed by providers who participate in managed care plans.

The analysis in Section VII is done with reference to the compilation of statutes and regulations in Appendix I. These laws address quality of care in general and are organized according to the components of quality identified by the study group. The focus is on those statutes and regulations that pose special problems to the minimum requirements necessary for the state to exercise its oversight of quality of care in managed care plans.

For each issue discussed, relevant research is included, much of it conducted by the University of Virginia, DHES. DHES examined QA and grievance plans of MCOs and conducted interviews with the plans to gain additional information (Appendices C, D, E, and F). DHES also conducted a survey of insurers concerning Chapter 54 (Appendix M) and contracted with Southeastern Institute of Research, Inc. to perform a consumer awareness survey (Appendix G). In addition to the work done by DHES, Section VII also includes results of the focused round tables held by VDH, and other research.

A. General Issues Related to the Quality of Care

The BOI has experience in regulating solvency and other financial operations of indemnity carriers, but the clinical expertise necessary to evaluating the quality of health care services is absent. The JCHC's study pursuant to SJR 67 included the observation that "some aspects of

managed care plans are outside the scope of traditional insurance regulation" including UR, medical necessity determinations, access, and "quality of care" issues.

1. Advantages and Limitations of the MOA

In January 1997, the BOI and the VDH entered into an interim MOA allowing the two agencies the authority and expertise to examine quality in HMOs. The purpose of the MOA was to create a pilot project whereby VDH could complement its experience in assuring the quality of care delivered in health facilities with the experience of BOI in regulating managed care plans. Because VDH had no regulatory guidance to implement existing statutes, the MOA provided a mechanism whereby the two agencies could discover issues in regulating the quality of care in HMOs. The two agencies understood that the State Health Commissioner probably could not effectively discharge his responsibilities under existing BOI authority and that regulations would be necessary to provide minimum oversight of quality of care. Nevertheless, the MOA allowed the agencies to identify potential regulatory problems (including the complex issues surrounding enforcement), explore possible solutions, and coordinate HMO examinations of quality and complaint investigations to achieve an appropriate level of regulatory oversight without duplication.

Despite these obvious advantages, the MOA had several limitations, which make it an undesirable long-term mechanism. These shortcomings exist because many of the challenges associated with regulating quality of care cannot be addressed adequately through the existing BOI statutory and regulatory authority. Establishing an MOA cannot create new authority for the VDH that does not already exist at the BOI. One limitation is that the current authority is deficient where issues of quality care arise. Second, the Health Commissioner has little authority independent of the MOA to compensate for these deficiencies. Third, sanctions available to the BOI and the State Health Commissioner to assure quality are inadequate. The only sanction available to the Health Commissioner is to recommend that the SCC revoke or suspend an HMO's license. The BOI's authority primarily addresses solvency, advertising, and trade practices, none of which are appropriate for addressing an HMO's improper attention to quality of care. Finally, it is inappropriate for the BOI to enforce VDH's findings of noncompliance.

2. Laws Pertaining to General Quality Issues

While the *Code* gives the State Health Commissioner broad authority to examine the quality of care in HMOs, it does not provide for regulations to be promulgated pursuant to this section. Absent appropriate regulations, VDH cannot establish standards for evaluating the quality of care in HMOs and cannot effect compliance.

Section 38.2-4316 of the Code addresses conditions for which the BOI may suspend or revoke an HMO's license. Section 38.2-4316.4 allows for suspension or revocation if "[t]he State Health Commissioner certifies to the Commission that the HMO is unable to fulfill its obligations to

furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth. . . ."

This section, too, is unsupported by any regulations, and there are no state standards by which the Health Commissioner can evaluate the HMO's ability to "furnish quality health care services." "Prevailing medical care standards" are not defined in regulation; presumably what is meant is the standard of care, the standard to which all licensed practitioners are held in Virginia. The standard of care is defined at §8.01-581.20 of the Code: "the standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth." However, this definition addresses practitioners, not organizations, such as HMOs.

Additionally, it would follow that if the State Health Commissioner is responsible for certifying that an HMO is unable to fulfill its obligations to furnish quality health care services, he should likewise be responsible for certifying that an HMO is able to furnish quality health care services. This is consistent with the requirement that the Health Commissioner examine the quality of health care services of any HMO licensed in Virginia. Again, there are no regulations to affect the development of standards by which to evaluate quality and no regulations to enforce noncompliance.

Neither the statutes nor the regulations contain explicit requirements for an HMO's quality assurance plan, structure, or functions. The only requirements for quality *per se* are that HMOs seeking licensure include a description of the procedures and programs they have adopted to assess the quality of health services provided and to assure availability and accessibility of adequate personnel and facilities.

Under the interim MOA between the BOI and the VDH, VDH participates with BOI in both initial licensure and market conduct examinations of HMOs. VDH examines the HMO's plan for QA and, during market conduct examinations, the degree to which the HMO has executed the plan. However, there is no statutory or regulatory requirement that HMOs comply with their QA plan and no provision for enforcement, nor are there standards for an adequate quality plan. Consequently, current law gives the HMOs broad discretion with regard to the content and execution of their quality programs.

B. Statutes and Regulations Addressing the "Consensus" Components of Quality: Chapters 43 and 34 of Title 38.2

The analysis of existing laws and regulations is done in the context of the components of quality to describe the dimensions of healthcare quality. (Appendix I). This discussion addresses the inadequacy of some of the current laws to provide minimum requirements to protect consumers. The analysis also summarizes the research undertaken by the University of Virginia, DHES. DHES surveyed managed care grievance and QA plans using questionnaires reviewed by the HB 2785 Study Group.

1. Complaint Resolution and Consumer Satisfaction

a. Problems in Current Laws

- Since VDH began investigating quality complaints brought by consumers about their HMOs, timely cooperation in obtaining enrollee information to conduct the investigation varies among them. Without specific regulatory authority, current law provides VDH with an inadequate basis to determine whether a complaint about quality has merit or to enforce compliance with findings of the investigations. Since HB 2785 explicitly requires the VDH to "receive and respond to" complaints concerning quality of care, this directive requires standards upon which an examination of quality can be founded.

- The regulations governing HMO complaint systems mandate that complaints be resolved in a "reasonable" amount of time, not to exceed 180 days. This time frame appears to be excessive.

- HMOs are the only managed care entities required by law to have a system for complaint resolution, although all entities performing UR are bound by the mandates of Chapter 54 of Title 38.2 and all insurers are required to keep records of written complaints for a period of three years.

- Although commercial plans are principally the purview of this study, it is useful to note the differences between the laws affecting definitions of key concepts for commercial plans and the DMAS' Medallion II contractors. Statutes for commercial plans define "complaint", and statutes for DMAS define "grievance" and "appeal." They do not define "complaint."

b. Research by the University of Virginia Department of Health Evaluation Sciences (DHES)

- The grievance plans studied indicate that there is great variability in content among managed care companies, particularly with regard to the appeals process and the levels of appeal. There are also a variety of definitions of "complaint," "grievance," and "appeal." Most of the plans had no member information about the help available from the BOI Consumer Services Section.

c. Focus Groups

- Participants in a provider and a consumer focus group expressed concern about complaint and grievance procedures. Several statements were made articulating the need for assistance in "navigating the system." Consumers and providers expressed the feeling that the process for filing a formal complaint with an HMO was complicated and confusing.

2. Access, Availability and Continuity

a. Problems in Current Laws

- HMOs must submit for licensure a list of their contracted providers and must update the list quarterly. This allows the Bureau to monitor the number of providers and provider turnover. However, the only standards for access are found at 14VAC §5-210-90.A. and are vague, requirements, for example, that the HMO "maintain adequate arrangements to assure both availability and accessibility of adequate personnel and facilities . . . . " Other access standards include "reasonable" hours of operation and after-hours emergency care; "reasonable proximity to enrollees within the service areas so as not to result in unreasonable barriers to accessibility"; "sufficient personnel" to "reasonably" assure that all services will be accessible; "adequate arrangements to provide inpatient hospital services"; and the availability of "the services of specialists." "Reasonable," "unreasonable," "adequate," "sufficient" etc. is not defined.

- The statutes addressing access to obstetricians and gynecologists (*Code,* §38.2-3407.11) and maternity length of stay *(Code,*§ 38.2-3414.1) are typical of laws passed in many states in response to public concerns that HMOs were too restrictive with certain types of services. However, this is a piecemeal approach to ensuring appropriate access to services and does not address many other services for which access is critical.

b. DHES Research

The QA plans of the HMOs surveyed appeared to emphasize accessibility of PCPs and appointment availability. A number of the HMOs mentioned specific PCP/member ratios and several reported standards addressing geographic accessibility. However, most of the ratios were expressed as the minimum number of patients a PCP had to accept rather than as a maximum limit acceptable to ensure access and appropriate time with the patient. The other managed care plans did not demonstrate a comparable emphasis on accessibility; this is likely a reflection of the fact that consumers in other forms of managed care have fewer restrictions on access to providers than consumers in HMOs.

c. Focus Groups

Participants in both consumer and provider focus groups raised concerns surrounding access to care. Concerns about access included access to services when the MCO denies authorization; availability of specialty providers; availability of appointments; waiting time to see a provider; and delay in services due to delays in approval. Access to particular drugs was also mentioned in the context where managed care companies use mandatory, rather than advisory, formularies. The study, however, did not examine these perceived problems to assess whether they are valid, and if so, the extent to which they are prevalent. Addressing these questions is regulatory in

nature, and goes beyond the scope of this study. However, separating meritorious complaints from perceptions is difficult without adequate laws and regulations against which to make such assessments.

d. Complaints Under Investigation at VDH

VDH received 84 complaints concerning quality of care in HMOs in the period between December 1996 and October 1997. Fifteen of the issues presented to VDH concern access to care. The number of complaints represents a small percentage of total HMO enrollment in Virginia (.064 per 1000 enrollees). Yet, apart from the prevalence of the complaints, VDH is now required to respond to these, and future complaints -- whether from HMOs or other managed care plans. Discharging this mandate is problematic under current law without adequate quality of care requirements.

3. Prevention

a. Problem in Current Laws

- The clearest and most comprehensive requirement for preventive health care services is found in the regulation setting forth the requirements for Essential Benefit Plans(14 VAC §5-234-50). Preventive care for children is required to be consistent with the current recommendations of the American Academy of Pediatrics; for adults, consistent with the recommendations of the American Academy of Family Physicians. However, this requirement is only for small group employers who choose the Essential Benefit Plan. Research by the BOI indicates that few small group employers are purchasing this plan for their employees.

- Large group insurers are mandated to provide Pap tests, mammograms, and child health supervision services for preventive care. HMOs are required to provide "basic health services" defined to include preventive health services. The accompanying regulation at 14 VAC §5-210-90.B defines preventive services as "services provided with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability . . . ." Individual insurance policies have no mandated preventive health services.

- By law, HMOs have the most stringent preventive health requirements. However, the regulation is very broad and it is unclear whether medical necessity criteria could conflict with the definition of "preventive" in the regulation.

b. DHES Research

- The QA plans and interviews with HMOs demonstrated that the companies are stressing prevention for both healthy individuals and those with certain chronic conditions such as

asthma and diabetes. Most of the companies surveyed are working on data collection for HEDIS measures and have developed preventive care standards with input from providers.

4. Credentialing

a. Problems in Current Laws

The Commonwealth's authority for licensure and professional qualifications of individual practitioners rests with the DHP. For the purposes of this analysis, credentialing is addressed with regard to the examination of professional qualifications performed by MCOs and the oversight of this process by the BOI, and through the MOA with the Department of Health.

- There are no statutes or regulations requiring managed care entities to examine the credentials of their providers beyond state licensure. State licensure, however, only requires practitioners to adhere to minimum standards of competence. MCOs generally maintain that the stringent qualifications for a large proportion of their practitioners is a hallmark of quality. Under current law, it would appear that state regulatory agencies have insufficient basis to examine the credentials of providers or the credentialing system of the MCO other than to ensure that licensure verification occurs.

- Much of the quality of health care rests with the individual practitioner. Consumers typically are not well informed concerning quality indicators for providers such as board certification and continuing education. However, the current regulatory guidance for standards for managed care provider credentialing does not permit the state any authority other than to assure minimal qualifications for individual providers through licensure by DHP. In particular, it is doubtful whether state oversight laws form a sufficient basis to verify the self-reported credentials of network practitioners, to determine whether an MCO's credentialing process is adequate, and to sanction the MCO for non-compliance with its own credentialing criteria.

b. DHES Research

DHES found that credentialing of providers was a prominent feature of the quality improvement plans examined and that managed care companies are committing significant resources to credentialing.

5. Consumer/Provider Education and Awareness

a. Problems in Current Laws

- With respect to consumer awareness, the disclosure requirements in Chapter 54 of Title 38.2, which apply to all health insurers, are confusing. The statute at §38.2-5402 (F)

requires that MCOs notify covered persons of the "review process." Without a regulation clarifying this section, it cannot be determined what exactly is meant by the "review process." Some members of the Study Group disagree as to whether it includes the appeals process.

As stated elsewhere in this study report, the appeals process in Chapter 54 is perceived by VDH as the most important quality of care protection provided by law. This protection is weakened by the confusing language in the statute and the lack of implementing regulations.

b. DHES Research

- All HMO plans surveyed measure consumer satisfaction, often contracting with an outside vendor or using the HEDIS member satisfaction survey.

- The consumer awareness survey for which DHES contracted with SIR surveyed a sample of 1,009 Virginia health insurance consumers. The results indicated the following about their experience with health insurance coverage, their awareness of grievance procedures, or both (Appendix G):

  - One third of Virginia health insurance consumers reported that they had called their health insurance company requesting information. Of that third, 20% reported having a difficult time getting answers.

  - One third of insured Virginians filing written complaints or grievances reported not knowing whether their insurer had a formal procedure for registering a complaint or filing a grievance.

  - One half of the respondents who have made verbal complaints had difficulty getting the complaint resolved.

  - Twelve percent of those surveyed said they had wanted to contact their health insurer with a complaint, but decided not to.

  - Four percent of Virginia health insurance consumers surveyed had filed a written complaint or grievance with their health insurance company; one third of these say they were never given a written copy of the grievance procedures. Another third who file a grievance said they found the insurer's procedures difficult to understand.

  - Nearly half of the respondents reported that they did not know to whom they would turn if they had a written grievance and found their health insurer uncooperative.

- A significant majority (75%) believe that their households do not seek medical services often.

- Two-thirds of the respondents are not aware of any procedure to file a complaint against a doctor, pharmacist, or other healthcare provider.

c. Focus Groups

In both the provider and the consumer focus groups the need for consumer and provider education was frequently articulated. Education concerning grievance systems and appeals was emphasized but consensus was apparent on the need for education on broader managed care issues. Although several participants spoke of the need for an ombudsman, there was also consensus that responsibility for education and assistance resides with all the players: employers, consultants, advocacy and professional groups, providers, consumers, and state agencies.

d. Ombudsman Programs in Other States

Currently, there are no state-funded managed care ombudsman programs in the United States. Florida has a voluntary program that is authorized, but not funded, by the state. California has a managed care ombudsman that is funded by three private health foundations: the Henry J. Kaiser Family Foundation, the Sierra Health Foundation, and the California Wellness Foundation. Funding for the program is $4 million for four years. The ombudsman will answer consumer questions and handle specific managed care complaints.

C. Chapter 54 of Title 38.2 of the *Code of Virginia* (Chapter 54)-- Utilization Review Requirements and Appeals

A weakness in the fee-for-service delivery system is that incentives to provide unnecessary services that have been in certain instances counterproductive to quality of care.[8] Utilization management involves setting guidelines for appropriate, cost effective, quality health care services. The UR appeals process in Chapter 54, including an expedited review when necessary, provides a means by which the patient's provider may challenge a managed care organizations' UR decisions. Sound criteria to determine whether a patient's treatment option is necessary combined with effective appeals to allow an orderly process for experts to reconcile differences in medical opinion provide the enrollee protection against unwarranted denial of medical services.

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[8]Peter Franks, M.D., Carolyn M. Clancy, M.D., "Gatekeeping Revisited -- Protecting Patients from Overtreatment" *Journal of the American Medical Association* (August 6, 1992), p. 424ff.

These protections are enhanced with state oversight to determine if the UR criteria are sound and whether the appeals process is functioning effectively. Unfortunately, it is difficult to reach any definitive judgment about the effectiveness of Chapter 54 because it was only enacted July 1, 1995. However, it is important to assess whether the oversight mechanisms are adequate to ensure that the law will perform as it is intended.

1. Problems in Current Laws

Chapter 54 incorporates the only protections specific to medical necessity determinations and appeals and safeguards the medical interests of Virginians enrolled in all types of managed care plans, not just those enrolled in HMOs. These provisions also constitute an effective mechanism through which providers can advocate for the medical needs of their patients. However, the statute does not provide sufficient systems-level protection for consumers. Additionally, there is no regulatory guidance or oversight responsibility for assuring compliance with the statute's requirements.

- Throughout Chapter 54, consumer protections are constrained by the restrictions placed on BOI's oversight authority stating that: "the [State Corporation] Commission shall have no jurisdiction to adjudicate controversies arising out of this section." This restriction is appended to several key sections that address the UM system and process required of MCOs. These restrictions were put into the text because of the BOI's recognition of their lack of expertise in evaluating the adequacy of clinical criteria for medical decision-making. For example, §38.2-5402, which stipulates standards and criteria for UR entities, and §5403, which requires a UR plan, both end with qualifying statements to the effect that the Commission has the right to determine that the insurance entity has complied with requirements for standards and plans, but the Commission has no jurisdiction to assess the *appropriateness* of these standards and criteria. Moreover, this restriction also appears following the sections requiring accessibility of UR staff (§38.2-5404) and records of UR appeals (§38.2-5409). Considered as a whole, the restrictions limit the Commonwealth's ability to provide minimum systems-level protections addressing medical necessity decisions.

- There are no regulations written for Chapter 54 that would clarify and explain its provisions. It is unclear in the statute as to what the role of the consumer should be in the review process regarding UR appeals and how the processes in Chapter 54 should be integrated with the grievance procedures provided in Chapter 43 of Title 38.2. For instance, the statute requires that providers be given notice of the MCO's initial decision to deny a benefit and notice of the right to seek a reconsideration of the decision (§38.2-5406 and §38.2-5407). No mention is made of enrollees as recipients of the notice in these sections. In addition, MCOs are required to give providers the UR standards and criteria and the list of physician advisors, but there is no mention of covered persons in this section either (§ 38.2-5402). The enrollee is not provided for in

the appeals process until the last level of appeal, the appeal of a final adverse determination.

The requirements for the peer reviewer (§38.2-5408) are open to interpretation. Although the statute stipulates that the peer reviewer shall not be an employee of the MCO, one HMO stated that its peer reviewers were employed by the medical group which has an exclusive contract with them. Doctors in this medical group have no patients except those that are insured by this HMO. The HMO maintains that it is in compliance with the statute.

Finally, with regard to HMOs, there is confusion concerning how the Chapter 54 appeals process intersects, if at all, with the grievance process mandated in Chapter 43 of Title 38.2. The two processes are very different (Appendix H, p. 21).

- The statute makes no provisions for enforcement or compliance. For example, there are no provisions for assessing the adequacy of the medical necessity criteria (§38.2-5402) or the UR plans used by MCOs (§38.2-5403.) Additionally, the statute makes no provision for appropriate sanctions based on the scope and severity of noncompliance.

In the past, BOI has been limited in its ability to resolve complaints against an MCO when the issue in dispute was the medical necessity for a covered service. Although BOI has attempted to advocate on behalf of the consumer, sometimes with success, when it became clear through the complaint handling process that the issue involved a difference in medical opinion between the managed care plan and the provider of medical care, BOI had to advise the complainant that it was unable to assist them further. Thus, while the BOI has the statutory authority to handle complaints, it lacks the medical expertise to determine appropriateness of care. On the other hand, VDH has the clinical expertise to evaluate the health plans' systems for determining medical necessity criteria and their appropriateness. The MOA provides a limited basis to review HMO UR procedures and requirements as they pertain to HMOs, but requirements for adequacy and appropriateness of UR criteria and enforcement of noncompliance with medical necessity criteria are deficient. In addition, a regulation clarifying and explaining the provisions of Chapter 54 could ensure that the protections intended to be provided by these statutes are understood by all.

2. DHES Research

- DHES conducted a survey of 31 HMOs and 200 other health insurers to determine the number of times consumers had appealed UR decisions in the last year, and to ascertain other information concerning the provisions of Chapter 54. Fourteen HMOs and 106 other health insurers responded. Forty-nine of the companies responded that they did not believe that the provisions of Chapter 54 were applicable to their organizations.

The survey found that 12 HMOs had received reconsideration requests (first level appeal); the number for each HMO ranged from 12 to 482. For the other insurers, 8 had received reconsideration requests with the number for each ranging from 2 to 73. Eleven HMOs had conducted appeals of adverse decisions (final level appeal), and the numbers ranged from one to 781 for each HMO. Seven of the other insurers had conducted appeals, with the number for each ranging from one to 37. While the numbers of appeals should be considered with respect to enrollment in the plan, the confidentiality of the survey does not permit disclosure of enrollment numbers. Nonetheless, these presumably high numbers of appeals for some HMOs underscore the importance of quality protection for consumers who may be denied medical care by their insurer.

- The examination of the grievance plans for HMOs and other insurers indicated that some of the plans contain procedures for Chapter 54 appeals that appear to be different than the requirements of the statute, particularly with respect to response times. None of the grievance plans contained any specific reference to Chapter 54. The research appears to indicate that MCOs frequently use internally developed medical necessity criteria rather than nationally accepted criteria such as Milliman and Robertson or InterQual.

3. Complaints Under Investigation by VDH

- Of the 84 quality of care complaints received by VDH in a nine-month period, 52 (62%) of the issues presented to VDH concerned HMO UR decisions. (See also the above discussion of Complaints Under Investigation by VDH on p. 28.)

4. Focus Groups

- Issues of medical necessity and managed care UR decisions dominated the discussion of the provider and consumer focus groups and emerged as the issue of most concern to both groups. Both providers and consumers related personal stories and anecdotes that would appear to indicate that serious errors occurred when the managed care entity denied or delayed authorization for treatment. Without independent examination and confirmation of the particular factual details involved, it is not possible to establish the accuracy of these accounts.

- Providers focused on the fact that a service is only covered if it is deemed medically necessary and that managed care entities define medical necessity in their sole discretion. A representative from the Virginia Dental Association offered as an example the denial of an authorization for reconstructive oral surgery to enable a patient to chew food; the managed care entity allegedly said that it was not medically necessary because the patient was able to maintain weight on a liquid diet. Concern was expressed about the apparent lack of accountability of individuals making medical necessity determinations. Without independent examination and confirmation of the particular factual details involved, it is not possible to establish the accuracy of these accounts.

- Providers expressed confusion about the appeals process and concern about the amount of uncompensated time required to appeal an MCO's medical necessity decision. One provider reported being told by an MCO that a denial of a request for durable medical equipment was not appealable under Chapter 54 and the question was raised as to whether drug formularies could be challenged under the statute. A number of providers indicated that they did not think that consumers knew of their grievance and appeal rights and that when they did try to grieve a decision they felt overwhelmed and confused by the process involved. Chapter 54 was cited as being confusing because there were no specifics addressing responsibility for implementation.

- Participants in the Consumer Focus Group expressed concerns that the grievance process was confusing and that consumers needed assistance in "navigating" the system. It was not just the HMO's grievance procedures that were confusing; the assistance offered by state agencies was also characterized by one consumer as confusing. A representative from a consumer advocacy group made the point that individuals need to know the appeals process when their managed care plan denies authorization for a service and that they need a written notice of denial that includes information on the appeals process.

- In the HMO Focus Group, there were several questions addressing UR appeals and Chapter 54. Three of the HMOs responded to the question concerning their use of Chapter 54; all three reported that the provisions for appeals in Chapter 54 were seldom used. The HMOs agreed that the determination of medical necessity was within the purview of the HMO.

5. UR Appeals Processes in Other States

In 18 states, the Department of Health monitors various aspects of the utilization review processes. Virginia's law is one of the more recent statutes providing appeals protections for managed care denials of care. Nine states have implemented or are in the process of implementing third party review of MCO UR decisions that is external, impartial, and independent of the health plan.

VDH reviewed the UR appeals laws in Connecticut, New Jersey, and Rhode Island (Appendix M, page 7) and compared them to Chapter 54. All these laws are directed at denial of treatment and require review by persons not involved in prior review of the case. Where the three states cited provide for impartial and independent review *after* the enrollee has exhausted the managed care organization's internal appeals process, Virginia law provides for impartial and independent review *within* the plan's internal appeals process: the peer reviewer is required to have not participated in any previous review of the case at issue and cannot be employed by or a director of the organization.

Connecticut, New Jersey and Rhode Island use independent utilization review organizations or peer review organizations. Virginia law requires the MCO to have physician advisors representing major areas of specialty that the MCO can use as needed for utilization review.

As Chapter 54 currently provides for impartial and independent review of appeals, the role of the state is to ensure that these provisions are observed by the managed care organizations.

D. Provider Concerns

HB 2785 directs the State Health Commissioner to "consider whether changes in existing law or regulations are warranted with respect to complaints by providers. . . ." The perception persists among providers that their concerns are not addressed by current laws. Among the most commonly cited concerns are conflicts of interests built into the reimbursement system; denials of services that the providers believe are medically necessary; and fear of retaliation by the MCO if the provider challenges its decisions. However, it appears that many of the key concerns that providers raise about quality have been addressed in recent legislation. Several protections for providers are included in §38.2-3407.10 of the *Code of Virginia* , including provisions for disclosure of network development by a managed care entity, and the terms for inclusion in the network; prohibition of "gag orders"; and prohibition of contract provisions waiving the provider's right to seek legal redress or requiring a provider to indemnify the MCO for its negligence. The previous discussion on Chapter 54 concerning UR and appeals is another example of a recent law addressing the attending provider's concerns about their patient's medical needs. Furthermore, other concerns are being examined by private accreditation bodies, or could be addressed with improvements in the current oversight mechanisms.

1. Conflict of Interests

Two aspects of managed care may act to create ethical conflicts for providers. One involves reimbursement. Capitation or risk-assumption on the part of the provider creates an incentive to do too little for the patient, and some payment methodologies that include bonuses for avoidance of hospitalization and specialty care may exacerbate that tendency. Although §38.2-3407.10 of the *Code* addressed this concern by requiring disclosure of all reimbursement methodologies, this provision does not affect the behavior of individual practitioners. Practitioners are bound by professional ethics. Those practitioners tempted to provide substandard care in exchange for profit do so at considerable risk because of the effective quality mechanisms provided by the DHP. Individuals who believe they have received poor care can bring their concerns to DHP, and both BOI and the Health Department refer quality problems to DHP whenever there is indication that an individual practitioner did not observe the standard of care (Appendix H, pp. 31-40).

The second conflict of interests is created when providers are bound by a limited network or formulary; when they must refer a patient to a network provider rather than one who can better help the patient, or when they must prescribe a drug less efficacious than an off-formulary drug.

These are valid concerns, but currently there are few mechanisms in the private or public sector to address them. National accreditation organizations do not review formularies nor the complaints against network providers. Moreover, state insurance regulators do not have the clinical expertise to make these judgments. This concern highlights the importance of state oversight by an agency with expertise in health care, and explains why many states have adopted coordinated regulation of managed care by departments of health and insurance.

2. Denial of Care

It was clear from the Provider Focus Group convened by the HB 2785 Study Group that a pressing concern that providers have with managed care is the denial of services on the grounds that they are not medically necessary. While Chapter 54 of Title 38.2 provides an appeal process for providers and requires review by a peer of the treating provider, many providers appear to be unfamiliar with the provisions of the statute.

There is currently no regulatory mechanism to address the perceptions of the medical community that medical necessity decisions by insurers are eroding the quality of care received by the public. Chapter 54 contains ten sections; seven sections include a declaration that the BOI has no jurisdiction to adjudicate disputes that may arise as a result of implementing the provisions of this statute. Four of these assertions affect the UR requirements, and three affect the UR appeals process. Under current law, the level of oversight extends to validating that MCOs have requirements and standards for UR; a UR plan; accessible utilization reviewers; procedures for emergencies, extension of services, safeguards for confidentiality of medical records; as well as requirements for the UR appeals process, including the collection of records on review procedures and decisions. No mention is made to the role of the State Health Commissioner in this Chapter. Without proper statutory authority conferring oversight duties upon the State Health Commissioner, it is uncertain how this concern can be addressed.

3. Fear of Termination

Providers perceive a threat to their livelihood if they challenge the decisions of an MCO with whom they have contracted. However, Chapter 54 (§38.2-5408 G) prohibits contract termination or penalties of any sort against a provider for advocating on behalf of a patient in a medical necessity dispute unless it can be demonstrated that the provider has established a pattern of bringing appeals that are without merit. This issue was also discussed during a focus group with the HMOs. Several HMO representatives responded that their plans had communicated to network providers that they welcomed attending physicians to advocate for the medical needs of their patient (Appendix K, pp. 21,22). Without judging the merit of this allegation, state enforcement of this provision will be difficult for any state agency. It is important to recognize that private accreditation organizations are seeking to address concerns such as these as they develop their standards.

4. Accreditation Standards Addressing Provider Concerns

Both NCQA and AAHCC/URAC have accreditation standards that actively incorporate input from practicing physicians and other providers in several areas of plan operations. NCQA promotes practitioner involvement in the development and implementation of quality improvement programs and in the development of practice standards and UR criteria. Health plans are also required to survey provider satisfaction with the UM process. NCQA has a standing Practicing Physician Advisory Council (PPAC), whose purpose is to examine physician concerns affecting quality. PPAC has been exploring ways to use the accreditation standards process to modify plan behavior with respect to many issues, including practitioner termination issues.

AAHCC/URAC requires the involvement of providers in network management on advisory boards, such as peer review, appeals, quality management, or other committees. URAC - which has now merged with AAHCC - was established largely to address provider concerns. Networks are required to have a "participating provider communication program" and to establish a provider dispute and appeals process for any disciplinary actions taken against providers.

In general, the directions of the private sector with respect to addressing provider issues pertaining to quality is encouraging. Having plans work together with providers with whom they must contract to be competitive may prove a more promising solution for certain provider issues than state regulations.

VIII. SHOULD ALL MANAGED CARE ENTITIES BE HELD ACCOUNTABLE FOR QUALITY OF CARE PROTECTIONS?

In the past two years, much of the legislation pertaining to quality has addressed all managed care plans rather than HMOs exclusively. The issue is whether provisions that currently apply to HMOs (e.g., such as requiring a complaint system or quality of care plan) should also be required of other forms of managed care. As noted in the Background, there are other managed care studies concurrently under way that are relevant to quality of care issues. The General Assembly has directed BOI to study the regulation of managed care plans. Specifically, HJR 611 directs BOI "to (I) identify the types of health insurance plans that should be considered as managed care plans; (ii) review the provisions of Chapter 43 of Title 38.2 and evaluate which provisions, if any, should apply to other forms of managed care health insurance plans . . . ; and (iii) identify any other appropriate provisions of the *Code of Virginia* or regulations promulgated by BOI that should apply to the types of health insurance plans identified as managed care plans." BOI is the most appropriate body to define "managed care health insurance plans" and determine which laws are applicable to these entities. Consequently, this study defers to the outcome of BOI's analysis on these issues.

With respect to whether the HMOs and other forms of managed care plans should be treated similarly under the *Code of Virginia*, it is crucial to recognize that the traditional regulatory distinctions have become blurred in this rapidly changing health care delivery business. The National Association of Insurance Commissioner's (NAIC) Risk-Bearing Entities Working Group concluded that the trend among state regulators is toward "pursuing initiatives to eliminate artificial distinctions that are irrelevant in today's marketplace." Thus, the Working Group's two findings present a reasonable basis for assessing whether it is justifiable to treat all managed care plans similarly under the *Code of Virginia*:

- All entities which assume health insurance risk must be subject to solvency and other appropriate consumer protection standards, irrespective of the name and form of the entity; and

- Any regulatory framework should foster a level playing field among risk-bearing entities that engage in similar insurance arrangements as opposed to a regulatory framework that favors the development or maintenance of any particular organizational form assuming insurance risk.

If the HJR 611 study determines that the statutes and regulations governing the quality of care in HMOs are applicable to other forms of managed care plans, then the policy interests of so-called "functional regulation" and "fair treatment" of entities bearing health insurance risk ("a level playing field") justify the desirability of applying these laws to other forms of managed care. In addition, the public health concerns for promoting safety, health, and welfare of Virginians bolsters the applications of these market and regulatory principles. From the public health perspective, the public's safety is potentially at risk in health plans that deny, reduce, or terminate services.

Another related issue is whether it is appropriate for the other forms of managed care plans to have procedures for QA, grievances and the like. For instance, in its simplest form, managed care may include pre-certification of hospital stays or UR to ensure services received by patients are medically necessary. As such, "managed care" processes exist in many different types of health insurance plans, including indemnity plans. More advanced forms of managed care, often referred to as PPOs and POS plans, not only require UR and medical necessity determinations, but also provide incentives for enrollees to receive care from network providers in order to obtain the highest level of the plan's benefits. Some PPOs and most POS plans also require an enrollee to select and use a PCP who provides primary care and coordinates access to other health care services. The most advanced form of managed care is provided by HMOs. Most HMOs require each enrollee to select a PCP, require use of network physicians (unless a POS option is included), and generally have smaller specialty networks than plans referred to as PPOs and POSs.

National surveys suggest that quality of care mechanisms are prevalent in PPOs. For instance, a national survey (Gold, Hurley, et.al. , 1995; Appendix Q) of 138 managed care plans in 20

metropolitan areas, including Virginia, found the following quality of care procedures used by PPOs:

- Sixty-two percent had a QA or Quality Improvement program and active patient grievance procedures;
- Thirty-one percent used quality monitoring and focused studies of specific conditions, and targeted quality of care improvement;
- Forty-five percent used physician profiling;
- Thirty-seven percent employed UR;
- Only seven percent developed practice guidelines.

In April 1997, the Association of Managed Healthcare Organizations (AMHO) conducted a survey of its members, principally PPOs and other managed care plans. The survey indicated that most of its membership have written, formal QA plans (more than 80 percent); QA committees (more than 90 percent); quality indicators for performance goals (86 percent); and patient appeals/grievance process (93 percent). Many conduct routine patient satisfaction surveys (70 percent). Nearly half use some form of outcome measures (43 percent); or monitor sentinel clinical events (45 percent), as well as profile physician performance on various quality indicators. In addition, the plans reported that nearly two-thirds routinely survey providers regarding access and other quality of care indicators, and nearly all plans responding offered a provider appeals/grievance process (Appendix Q).

Research by DHES on the quality of care procedures in non-HMO insurance organizations licensed in Virginia could not confirm or invalidate the general patterns above. This was due to the fact that some of the companies that said they had QA plans did not submit the plans.

If regulation of other forms of managed care is determined to be desirable, the appropriate standards for quality and grievance plans could be determined through the rule-making process.

IX. CONCLUSIONS

State laws cover many areas of quality appropriate to the state oversight system. However, the oversight system can be made to perform more effectively to protect consumers by addressing the weaknesses in systems-level safeguards.

The appropriate role of state regulatory agencies is to ensure systems-level protections provided by law. In 21 states outside of Virginia, the Department of Health is responsible for assuring compliance with state managed care quality standards. As the health care system in Virginia continues the transition to managed care, regulatory change is needed to keep pace with the

changes in health care delivery and reimbursement. Two areas need attention. First, the State Health Commissioner and the Department of Health lack sufficient statutory authority and regulatory guidance for appropriate oversight of HMO quality. HB 2785 directs the Health Commissioner to examine the quality of health services and complaint systems in HMOs, and to review and respond to complaints of enrollees in managed care plans. Neither current statutes nor the MOA between the BOI and the VDH provide the authority to appropriately execute this directive.

A second opportunity to improve the state oversight system involves the implementation and administration of Chapter 54 of Title 38.2. This chapter provides the most comprehensive protections for managed care enrollees who are denied coverage for health care services deemed by their health plan not to be medically necessary. However, the state can do more to assure this important consumer protection. The provisions of Chapter 54 are not well known or understood by providers and consumers. Limitations on systems-level protections are written into the statutes and the absence of regulations for this chapter further limits state oversight of compliance and enforcement. The subject of the legislation, medical necessity determinations and appeals, is beyond the scope of the traditional expertise of the BOI. VDH has the expertise to determine the adequacy of and adherence to UR criteria, important provisions in the statute, but unlike other states, the Virginia statute provides no role for the Health Commissioner.

These problems may provide some insight into the worries that consumers have about the services they receive in managed care plans and why some believe individual protections such as an ombudsman and independent external appeals process are appropriate solutions. However, the state does assist individual consumers in resolving their disputes. For example, one role of the Consumer Services Section of the BOI is to educate consumers and, in some instances, to advocate on their behalf with their insurance companies. In addition, VDH has the expertise to assume additional educational responsibilities in assisting both enrollees and providers with internal HMO grievance and appeals processes. To extend the ombudsman role to include adjudication of conflicts would require the state to assume the roles of both mediator and regulator, an inherent conflict.

Moreover, a new external appeals process protection for denial of treatment may not be needed at this time if Chapter 54 is administered by an agency with clinical expertise, and if adequate regulatory guidance is available to preserve the independence and impartiality of these critical medical decisions. To achieve this policy objective requires that agencies responsible for oversight of quality have proper expertise.

Private sector accreditation of managed care has made significant contributions to quality improvement that complement, but should not supplant, state oversight.

Private sector efforts by HMOs and national accreditation organizations continue to provide a focus on improvement of health care and measurement of quality. State oversight of HMOs will be accomplished most efficiently in collaboration with private-sector quality initiatives.

Modifying plan behavior through a private accreditation process is an effective avenue for quality improvement that offers several advantages to State policy makers.

Consumers and providers need more education about managed care.

There is a need for more and better education about managed care issues for consumers and providers as demonstrated in the focused round table discussions and the consumer awareness survey. Consensus was evident regarding the parties responsible for better education and awareness: employers, professional and advocacy groups, managed care organizations, consumers, providers, and state agencies. In particular, consumers need to be better informed about the current protections afforded them through the laws, their health plans, and through the BOI and VDH.

HMOs have significantly more legal requirements addressing functions performed by other licensed managed care organizations.

Statutes and regulations addressing quality of care in HMOs expressly address particular functions, such as quality assurance plans, complaint procedures and provider networks. The lack of similar requirements for other managed care organizations performing the same functions creates a gap in consumer protection and contributes to a competitive disadvantage for HMOs.

Current VDH resources are insufficient to carry out legislative mandates for quality oversight.

Although it is difficult to estimate the necessary resources, if it is desirable forVDH to provide oversight of all forms of managed care, additional staff at VDH are needed to assist with complaint investigation and to conduct examinations, and additional funding will be needed for expenses attendant to these functions. The resources needed will depend on the degree to which other forms of managed care are brought into the scope of VDH's regulatory purview.

Federal laws and oversight complicate state oversight of managed care. However, opportunities for oversight partnerships maybe possible.

Health care benefits provided through Medicare, Medicaid, CHAMPUS, federally-funded plans or ERISA self-funded plans are exempt from much or all of state oversight requirements governing quality. Nevertheless, Virginia can signal its interest to work in partnership with the federal government and large employers to ensure quality protections in employer-funded health plans.

X. WHAT IS THE *APPROPRIATE* ROLE OF THE COMMONWEALTH IN MONITORING AND IMPROVING QUALITY OF CARE IN MANAGED CARE ORGANIZATIONS?

HB 2785 requests the State Health Commissioner to make recommendations on whether additional changes are needed in the Commonwealth's oversight responsibilities for quality of care in commercial MCOs. This section presents options for changes necessary for the state to have effective minimum requirements to assure quality of care in managed care plans. These options are not intended to represent all possible options, but rather the most viable or frequently advocated options.

A. POLICY OPTIONS

Systems-level Safeguards Can Be Improved

Option #1a: Amend the *Code of Virginia* at §32.1 to grant the State Health Commissioner authority to certify the adequacy of the HMOs' quality and grievance plans and to ensure compliance. The statute would also direct the BOH to promulgate a regulation defining the certification process that would:

- direct VDH to certify that the health plans meet minimum standards for adequate quality and grievance systems as defined in the regulation;
- allow VDH to verify implementation and execution of the quality and grievance systems and would permit the health plans reasonable latitude for innovation;
- direct the BOH to determine the frequency and expectations for onsite surveys of the health plans, and make provisions for deemed status for accredited health plans;
- require that the BOH determine a schedule of reasonable sanctions based on scope and severity of noncompliance, and an appropriate mechanism for financing examinations.
- require that VDH report its HMO certifications of quality and grievance programs to BOI annually.

Option #1b *(alternative to #1a)*: Request legislation to codify the existing MOA between VDH and BOI with respect to the shared responsibility for oversight of HMOs, and to

expand its authority to include all MCOs as defined by the BOI under HJR 611.

Option #1c
(alternative to #1c): Make no changes to the current oversight authorities.

Option #2: Request legislation defining key terms such as "inquiry," "complaint," and "grievance," etc.; and requiring a standard classification scheme for quality complaints to be used by MCOs and appropriate state agencies.

Option #3: Request that the statutory provision at §54.1-2906 be amended to require that MCOs report provider disciplinary actions to DHP.

Option #4a: Request legislation to transfer Chapter 54 from Title 38.2 of the *Code* to Title 32.1 and confer authority for administering and enforcing its provisions to VDH through the certification process. The legislation additionally would:

- Authorize regulations for VDH to discharge oversight responsibility. The regulatory authority would only extend to systems-level compliance with Chapter 54 of Title 38.2, including, but not limited to, assessment of UR plans and criteria; UR appeals process, including disclosure of the review process to covered persons; and sanctions based on the scope and severity of noncompliance.

- Clarify requirements for the submission and collection of appeals' data (§38.2-5409)

- Amend Chapter 54 to include consumers in all levels of appeal

Option #4b
(alternative to #4a): Make no changes to Chapter 54 of Title 38.2 at this time.

Option #5: Request budget authority to support the HB 2785 mandate that VDH receive and respond to individual enrollee complaints by conducting system-level reviews of managed care plans.

Option #6: Request legislation requiring an independent and external appeals process to resolve questions of medical necessity that have not been satisfactorily resolved through the commercial MCO's internal appeals process.

Option #7: Seek legislation to establish and fund an ombudsman for health insurance issues to educate consumers about their rights and responsibilities, mediate disputes between insurers and consumers, and advocate for mutually satisfactory resolutions. The ombudsman would most appropriately reside with an independent private contractor.

Consumers and Providers Need More Education about Managed Care

Option #8: Amend the *Code* at Chapter 54 of Title 38.2 to require disclosure of the UR appeals process at the time that care is denied and/or in the Evidence of Coverage and other communications from the health plan.

Option #9: Create a public/private partnership with VDH as the facilitator to organize educational strategies to help enrollees, purchasers, and providers become better informed about their rights and responsibilities regarding complaints, grievances, and appeals. Participating organizations could include the Virginia Association of HMOs, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, consumer advocacy groups, businesses, other organizations and appropriate state agencies. (*No legislation is required for this option.*)

Option #10: Currently there is no standardized coding to indicate payor health plan type (e.g., HMO, PPO, POS, etc.) VDH's health data reporting contractor is committed to a strategic plan to develop hospital inpatient data with health plan identifiers. With this information, VDH or its contractor can assess and report information by specific plan type.

Option #11: VDH or its contractor will work with managed care plans to collect audited HEDIS data submitted voluntarily. The State Health Commissioner will encourage health plan participation in HEDIS reporting and will publish a list of those managed care plans that voluntarily participate with VDH's health data reporting contractor.

HMOs Functions Are More Regulated than the Same Functions Undertaken by Other Managed Care Organizations

Option #12: Support the underlying policy for options presented by BOI in their study pursuant to HJR 611that codify provisions in Chapter 43 of Title 38.2 which are applicable to other forms of managed care health insurance plans.

Option #13: Amend Title 32.1 of the *Code of Virginia* to increase the size of the State BOH to twelve members, with the additional appointee to be a representative of a managed care plan.

Possible Opportunities for Federal/State Collaboration Involving Self-funded Plans

Option #14: BOI should notify the Assistant Secretary of Labor, Pensions & Welfare Benefits Administration, U.S. DOL, about Virginia's interest in exploring a possible future role for BOI in resolving ERISA complaints on behalf of the citizens of this Commonwealth.

Option #15: Track ERISA-protected quality of care complaints through BOI with the assistance of other state agencies, such as DPT.

B. STATE HEALTH COMMISSIONER'S RECOMMENDATIONS

The following options are recommended to strengthen the existing laws and to provide for the least minimum requirements to ensure quality of care for all Virginians in licensed managed care plans:

1. Improve systems-level protections (Options 1a, 2, 3, 4a, and 5)

These options permit the certification by VDH of the adequacy of mandated quality assurance and grievance procedures; allow for sanctions for non-compliance; and strengthen protections for consumers. The changes recommended for Chapter 54 are necessary to ensure the important safeguards against arbitrary denials of care.

2. Facilitate managed care education for consumers and providers (Options 8,9,10, and 11)

Option 8 is recommended to ensure that consumers are aware of their legal right to appeal managed care denials of coverage. The other options do not require legislation and address a need for education that was clearly articulated over the course of this study.

3. Support BOI policy regarding regulation of managed care entities by function (Options 12 and 13)

Because the distinctions between HMOs and other managed care organizations have become increasingly blurred, it is appropriate to examine the functions that MCO's are performing and bring them under regulatory oversight where it is applicable.

4. Address managed care protections for Virginians in employer-funded plans (Options 14 and 15)

Many states have become concerned about the lack of protections for consumers in ERISA self-insured plans, and it is likely that Congress will address this issue. In the meantime, the

recommended options are very easy to implement and are an important step toward quality health care for all Virginians.

C. OPTIONS NOT RECOMMENDED

1. Codify the MOA between the BOI and the VDH (Option 1b)

This option is not recommended because the MOA cannot provide for authority that BOI currently does not have and because it is not appropriate for BOI to enforce VDH's findings of HMO non-compliance with applicable statutes and regulations.

2. Independent External Appeals Mechanism (Option 6)

Chapter 54 of Title 38.2 has provisions similar to those in other states where an independent appeals mechanism has been implemented. If authority for oversight and regulations for Chapter 54 is transferred to VDH, and the statute's protections enforced, there should be no need for an external appeals mechanism at this time. Also, ERISA may pre-empt self-funded employer-sponsored plans from state requirements.

3. Ombudsman (Option 7)

The action is not necessary at this time. Many complaints are resolved through education. BOI provides assistance to consumers and VDH is proposing to assume increased enrollee educational responsibilities. Improvement of systems-level oversight of complaint and UR appeals systems can also improve the perfomance of the health plan. These approaches should be implemented first. Furthermore, functions of advocacy and mediation may pose conflicts of interest for state agencies that regulate managed care. Finally, this consumer protection would be costly.

4. Make no changes (Option 1c and 4b)

These options are unsupportable because the current mechanisms to ensure quality in managed care are not sufficient.

APPENDIX A

HOUSE BILL 2785

ENROLLED

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, relating to accident and sickness insurance; health maintenance organizations; contents of policies; State Health Commissioner review.

[H 2785]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, as follows:

Article 7.

Review of Health Services Quality.

§ 32.1-122.10:01. Review of health maintenance organizations.

A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§ 38.2-4301 and 38.2-4302 and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.

B. For the purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.

C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.

D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.

E. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in § 38.2-4308; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § 38.2-4308; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § 38.2-4308.

F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§ 38.2-305. Contents of policies.

A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

B. Each *new or renewal* insurance policy ~~or~~, contract, *certificate or evidence of coverage issued to a policyholder, covered person or enrollee* shall be accompanied by a notice stating substantially:

"IMPORTANT INFORMATION ~~TO POLICYHOLDERS~~ *REGARDING YOUR INSURANCE*"

"In the event you need to contact someone about this ~~policy~~ *insurance* for any reason please contact your agent. If *no agent was involved in the sale of this insurance, or if* you have additional questions you may contact the insurance company issuing this ~~policy~~ *insurance* at the following

address and telephone number [Insert the appropriate address and telephone number, toll free number if available, for the company's home or regional office].

Health maintenance organizations shall add the following: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia *State Corporation Commission's* Bureau of Insurance at: [Insert the appropriate address, toll free phone number, and phone number for out-of-state calls for the Bureau of Insurance.]

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available."

C. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

D. This section shall not apply to surety insurance contracts.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, *38.2-305,* 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4308. Complaint system.

A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of the complaints shall be maintained for the period set forth in § 38.2-511.

C. The Commission ~~or~~ , *in cooperation with* the State Health Commissioner ~~may~~, *shall* examine the complaint system. *However, at its discretion, the Commission may accept the report of examination conducted by the State Health Commissioner instead of making its own examination.*

§ 38.2-4315. Examinations.

A. The Commission shall examine the affairs of each health maintenance organization as provided for in § 38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

~~B. The State Health Commissioner may examine the quality of health care services of any health maintenance organization or providers with whom the organization has contracts, agreements, or other arrangements according to its health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth.~~

~~C. For the purpose of examinations, the State Health Commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the~~

~~providers concerning their business.~~

~~D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.~~

~~E.~~ *B.* Instead of making its own examination, the Commission ~~or State Health Commissioner~~ may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, *38.2-305,* 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That the State Health Commissioner, in cooperation with the Bureau of Insurance, the Department of Health Professions, and other state agencies as appropriate, be requested to study the quality of health care services provided by health maintenance organizations.

A. The study should (i) examine quality of care mechanisms currently in place for health maintenance organizations (HMOs) and providers with whom they contract, including, but not limited to, state and federal statutes and regulations and review by private accrediting bodies, such as the National Committee for Quality Assurance; (ii) assess the sufficiency of these mechanisms for ensuring quality and providing health care consumers with a means of having their inquiries and complaints addressed; (iii) determine the extent to which such quality of care mechanisms currently exist for forms of managed care other than HMOs (described above) and whether any or all of such mechanisms should be expanded to entities other than HMOs; (iv) examine how the Department of Health and the Bureau of Insurance can coordinate their regulatory roles for ensuring quality of health care services in a manner which minimizes overlapping of authority and duplication of resources; and (v) identify the appropriate role of the Department of Health and any other appropriate state agencies in monitoring quality of care provided through HMOs, other managed care plans, and the providers with whom they contract.

B. The study also should consider whether changes in existing law or regulations are warranted with respect to: (i) the system for investigating and resolving complaints, including whether such system should include complaints by providers and other interested parties on

matters which are not purely contractual in nature; (ii) addressing complaints regarding alleged violations of applicable laws or regulations and the manner in which such laws and regulations should be enforced in the Commonwealth; and (iii) whether there is a need in the Commonwealth for a mechanism to be created for the purpose of adjudicating controversies and resolving complaints in connection with alleged violations of applicable law or regulation.

C. The State Health Commissioner also is requested to submit a report by October 1, 1997, to the Governor, the Joint Commission on Health Care and the General Assembly which, in addition to the matters to be reported on as set forth above, (i) recommends the appropriate role of the Commonwealth in monitoring and improving the quality of care in managed care plans which either require or create incentives for covered persons to use health care providers managed, owned, under contract with or employed by the health carrier; (ii) recommends the Commonwealth's role in providing consumer information on managed care issues; (iii) assesses the licensing functions for individual and institutional health care providers currently performed by the Department of Health Professions and the Department of Health, and determines, in light of current health care market conditions, whether any modification or consolidation of these functions would enhance the Commonwealth's efforts in overseeing the quality of managed care health plans; and (iv) evaluates whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans, and, if so, whether the Department of Health or another entity should administer the process. In formulating his recommendations, the State Health Commissioner is requested to optimize the contributions of other public and private entities such as Virginia Health Information, Inc.'s, role in consumer education, as well as identify other public and private partners able to support these functions.

3. That, in concert with the State Health Commissioner's examination of the quality of health care services provided by health maintenance organizations, the Department of Health be requested to receive and respond to complaints from managed care plan enrollees regarding quality of care issues which are forwarded to the Department by the Bureau of Insurance's consumer complaint review program.

APPENDIX B

STUDY GROUP WORK PLAN

APPENDIX B: HB 2785 WORK PLAN

QI: What is the current role of the Commonwealth in monitoring and improving the quality of care in HMOs?

A. Define the scope of health care quality that should be subject to oversight by the Commonwealth which can serve as an organizing principle of this study.

B. Identification of Laws, Regulations and Penalties Addressing Quality of Care in HMOs

Department of Health
Bureau of Insurance
Department of Health Professions
Department of Medical Assistance Services
Federal Laws and Regulations

Objective: *To identify the existing oversight responsibilities among the state agencies in order to determine the extent to which quality assurance and consumer protections exist.*

Tentative Deadline: *Late May 1997*

QII: How adequate are the current quality of care mechanisms, both private and public, for consumers? For providers?

A. Hold Focus Group meetings for providers, consumers, and HMOs to identify quality concerns.

B. Survey and summarize the quality assurance plans for all HMOs licensed in Virginia.

C. Survey and analyze the federal and state laws and regulations for consumer grievance and complaint policies and procedures that affect licensed HMOs and their enrollees in Virginia.

D. Identify all HMO internal mechanisms for provider grievances and complaints from the surveys of (B) and (C) above, including an analysis of complaints that are "not purely contractual in nature".

E. Analyze and summarize the utilization review appeals mandated by Chapter 54 of the *Code of Virginia*.

F. Examine the adequacy of NCQA and other public and private sector standards for ensuring quality.

G. Review issues related to practitioner licensing in the context of oversight responsibilities for managed care.

Objective: *To assess the existing mechanisms, identify deficiencies, determine the extent to which regulators, purchasers, private sector entities, or the individual consumer are accountable for improving them.*

Tentative Deadline: *Mid to Late June*

QIII: Should all managed care entities be held accountable for quality of care protections similar to those that exist in HMOs?

A. Identify the various types of risk-bearing entities regulated in the state. (Coordination with BOI study on HJR 611)

B. Assess the degree to which the following quality components apply to the entities identified above: Use seven consensus quality components (e.g. prevention, etc.)

Objective: *To assess the appropriateness of applying quality of care mechanisms to all managed care plans.*

Tentative Deadline: *Mid to Late July*

QIV: What is the appropriate role of the Commonwealth in monitoring quality and informing consumers?

A. Identify gaps in existing functions.

B. Identify areas of overlap and duplication.

C. Recommend new functions including the provision of appropriate consumer information through current mechanisms such as NCQA accreditation, HEDIS, and VHI.

Objective: *Options*

Tentative Deadline: *Late August*

Round Tables with Stakeholders:	Early September
Final draft report to the State Health Commissioner	Early to Mid-September
Final Report to the Secretary	Mid to Late September
Final Report to the JCHC & General Assembly	October 1, 1997

APPENDIX C

ANALYSIS OF HMO QUALITY ASSURANCE PLANS

Appendix C: Analysis of Quality Assurance Plans - HMOs

Methodology

At the commencement of the study, all quality assurance plans from HMOs licensed in the Commonwealth on file with the Bureau of Insurance were copied and sent to the Department of Health Evaluation Sciences at the University of Virginia. Researchers answered the questions contained in the analytical frameworks based on these documents. Interviews with the person or people deemed most responsible for these plans were arranged to go over the lists of questions for clarification. After three interviews with HMO representatives, it was determined that the documents received at DHES from the Bureau of Insurance were not the most current quality assurance plans. In order to rectify this problem, the study methodology was changed slightly, allowing the HMOs to present their current plans. A tracking chart listing the HMOs and the status of their submissions follows the analysis of the grievance plans in Appendix E.

Based on several descriptive factors, a representative sample of HMOs licensed in Virginia was chosen for inclusion in the study. These factors included age of the plan, geographic region of service area, status of NCQA accreditation, number of total members and number of Virginia members, state of domicile, and tax-status. A total of seventeen (17) HMOs were chosen. In some cases, more than one plan from a particular company was chosen in order to make comparisons within companies. Contact information for each HMO was obtained from the Virginia HMO Association.

A research assistant initiated contact with the people deemed most responsible for QA plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the quality assurance plans. Each plan was instructed to complete the questions with relevant citations noted and to send current QA plans to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study.

The following HMOs were contacted regarding their QA plans: Aetna, Cigna-MidAtlantic, Cigna-Virginia, HealthKeepers, HMO Virginia, John Deere, MD-IPA (part of MAMSI), NYLCare, Optima, Optimum Choice (part of MAMSI), Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), QualChoice, Sentara, US Healthcare (now part of Aetna), and Virginia Chartered. Virginia Chartered was dropped from the study because no

person able to respond to the questions could be reached within the study time frame. Responses were received from John Deere, MD-IPA, NYLCare, Optimum Choice, Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), NYLCare, HealthKeepers, HMO Virginia, Aetna/United Healthcare, and QualChoice.

Once the documentation and completed questionnaires were received at DHES, the researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions. Quality assurance plans were compared to NCQA standards and to the seven components of the definition of quality determined by the August 1996 round table (see Chapter 2).

Analysis

Quality Assurance Plans

Twelve HMOs returned the completed questionnaire concerning their quality assurance plans. One HMO did not return the completed questionnaire but did provide documentation of their procedures, so analysis was done on the information available. One company did not submit a current quality assurance plan with their responses, so their answers could not be verified. The response rate, including the plan that only provided their QA plan, was 81%, and it can be reasonably assumed that these thirteen HMOs may be deemed a representative sample of all HMOs in the Commonwealth. Three companies, Aetna (which owns United Healthcare), Trigon (HMO Virginia and HealthKeepers), and MAMSI (MD-IPA and Optimum Choice), use the same quality assurance plans for all their HMO products. Therefore, analysis was done on the quality assurance plans submitted by each company rather than each plan, resulting in a total of nine QA plans. Certain patterns in these QA plans emerged that merit consideration. Each question in the analytical framework has been answered using responses from the companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the quality assurance plans for each plan. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF HMO QUALITY ASSURANCE PLANS

1. Prevention

a. Identify the QA plan's goals and objectives that address preventive care. Name, if applicable, specific HEDIS measures that will be undertaken (e.g., cholesterol screening, diabetic retinopathy exam, mammography recommendation, etc.) If HEDIS measures are planned, describe what efforts the plan is making to ensure valid and reliable encounter data.

Seven companies reported that they will be collecting all HEDIS measures utilizing HEDIS methodology as evidenced in their QA work plan. These companies had specific care objectives for preventive care in diabetes, asthma, mammography, and immunization among others. Specific goals and objectives were outlined in the QA plans. One of these seven companies specifically mentioned their plans to have an outside contractor examine their data collection and reporting exercises for accuracy; another of the seven described a list of HEDIS measures and targets they will be examining along with their methodology. One company did not report using any HEDIS measurements, but did outline many preventive studies that are related to HEDIS measures. Another company also doesn't use HEDIS measures, but did state they conduct annual reviews on at least four preventive services.

Comments: Many companies are using HEDIS recommendations and measures to study preventive care. This information was found in the QA plans of all companies. NCQA requires these activities for accreditation.

b. Are prevention guidelines developed by the HMO or does the plan make reference to national practice guidelines? How?

One company stated that they develop guidelines for both adult and pediatric populations based on and adapted from the American Academy of Family Physicians (AAFP), the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics (AAP). Annually, preventive health guidelines and practice guidelines are reviewed by peer review committees, medical directors, and quality improvement committees. This company also provided specific quality of care measures for their plans over a three-year period and compared them to Healthy People 2000 criteria.

Six companies made reference to internal development of prevention guidelines by using accepted practice standards from various professional associations and the Agency for Health Care Policy and Research. One of these companies documents the source of recommendations at the end of each internally developed guideline; these sources include Healthy People 2000, American College of Physicians (ACP), AAFP, AAP, American College of Obstetrics and Gynecology (ACOG), and the US Preventive Services Task Force. One of these companies has adopted the US Preventive Services Task Force Guidelines as its standard for

preventive services, and one company used USPSTF guidelines to help craft internally developed company guidelines. One company used preventive standards published by Health Care Operations. Two companies did not elaborate.

Only one of the nine companies mentioned which national organizations were consulted within their QA plans, but the provisions for guideline development were available in the other plans.

Comments: Only one company reported that they use guidelines developed by an outside agency. Most plans uses national standards and modify them for use in their particular plans. The methods used to reach these guidelines are often not clear, but the process does allow for much feedback from many facets of the company.

c. Are there indications in the plan that guidelines for preventive care are shared with providers or that provider input was solicited?

One company reviews their guidelines for preventive care annually using a committee of medical directors and peer reviewers. Guidelines are forwarded to all members, including providers, annually. For one company, guidelines are forwarded to all plan providers for comment within a 45 day period. Another company forwards their draft guidelines to a peer review committee and the plan's medical directors for comment; final guidelines are distributed to all members and practitioners annually, but feedback is not solicited at this stage. One company distributes a reference guide to all providers and has provider participation on guidelines committees. One company has their guidelines reviewed annually by a subcommittee of providers. Two other companies utilize appropriate providers during guideline development and review all guidelines annually. One company utilizes a physician QA committee that aids in all aspects of guideline development and review. One company reported that they do not currently share guidelines with providers, but they have implemented distribution for 1997 and demonstrate provider input through their preventive services committee. This information was found in the QA plans of two companies, and it was absent in the QA plans for seven companies.

Comments: Provider input into development is important if a plan wants their providers to embrace their guidelines. These companies seem to value and seek provider input.

2. Complaint Resolution

a. What provisions does the plan make for aggregation and analysis of complaints and grievances?

Two companies aggregate and analyze their data on a quarterly and yearly basis, and continue to track each type of complaint over multiple years. This was stated in the QA plan of both companies. One company separates complaints and grievances from denials and appeals, with the former being analyzed every six months and the latter being analyzed at least annually; this information was in their QA plan.

One company sends monthly reports to its regional offices as well as providing quarterly and annual reports; this company uses the information during the recertification process for each of their offices. One company summarizes their data at least annually and aggregate data by provider. In addition, all written grievances are forwarded to the provider involved (with the permission of the member). One company logs all complaints and analyzes them to identify areas for improvement; appeals for denial of care are analyzed separately.

One company referenced a Quality of Care Identification and Tracking Process, but details about this process were not provided. Another company mentioned a Service Enhancement Tracking System, but again, details were not provided.

One company did not answer this question, but their QA plan shows many provisions for routine aggregation and analysis of complaints and grievances.

Comments: Information about complaints and grievances is gathered on a regular basis, as is required by NCQA and parts of the Code of Virginia. Frequency of reporting does not always appear in the QA plans, but mechanisms for collecting the data are documented.

b. What is the physician's office told with respect to appealing a denial for a service? Are they given the name and number of the medical director? Is there a physician/provider helpline?

One company does not deny payment for treatment ordered by a patient's PCP. However, if there is a denial of coverage, the physician is contacted with a name and number to call. Two companies notify physicians about denial of services either verbally or in writing, depending on the type of denial. Information about how to appeal is available either verbally at the time of denial or in the letter of denial.

One company provides both verbal and written responses to physicians for all denials of service. One company sends copies of all letters of denials directly to the physician's office. This letter mentions that an appeal process is available, and this information can also be obtained by phone.

Two companies have a special process in place to inform providers about denials. One company submitted a separate policy that described the process. One company made reference to their Medical Appeals policy.

The name and number of the medical director are available upon request at seven companies; one company includes the name of the deciding medical director in the letter of denial. This information could not be determined for the company that did not submit survey answers.

One company does not have a specific provider helpline, but there is a department that focuses on their needs. Four companies do have a specific helpline dedicated to providers, while two utilize their regular customer service department to help providers. This information could not be determined for the company that did not submit survey answers, nor was it found in the QA plan for the company that did not answer this question.

Comments: This information should be contained in written notifications of denial and communicated verbally when a provider calls the plan. This information is often found in provider handbooks.

c. What provisions does the plan make for systematic follow-up and corrective action on identified problems?

Eight companies have a formal process for systematic follow-up and corrective action. Complaints are aggregated and analyzed for patterns, and the QA plan makes provisions for examining them further. Complaints regarding providers are handled by a very detailed process described in the QA plan of four companies. One company documents problems in their QA committee meeting minutes and reviews provider problems at the time of recredentialing, but this was not documented in their QA plan.

One company reported that they have appropriate departments work together to resolve issues, but no formal system was described in their QA plan.

Comments: Most plans have a formal system for follow-up and corrective action about identified problems, but details were not (perhaps could not) be given in the QA plans.

3. Access and Availability

a. What activities does the plan describe for monitoring access and availability?

One company has a special department that monitors the ratio of members to primary care physicians (PCP). Provisions appear in the QA plan to monitor this ratio and remedy problems, but there is no indication of frequency of reviews. Two companies have several objectives for monitoring access in the QA plan, but do not give specific targets. Two companies assigned a person to monitor these issues in their work plan, but did not state specific targets. One of these two companies did, however, provide an extensive chart in their written responses to the study question. Three companies described in detail their processes: access surveys, consumer surveys, and provider surveys. One company did not specifically mention access in their QA plan, but it does track all quality improvement measures on a quarterly basis.

Comments: Most companies are monitoring access and availability.

b. What are the standards for appointment availability for routine, urgent, emergency care?

Standards for appointment availability for routine care ranged from 3 days to 12 weeks; for urgent care from 24 to 48 hours; and for emergency care from immediately to within 24 hours.

One company set the appointment standards within 90 days for routine care and within 24 hours for urgent/emergency care. These standards are not indicated in the QA plan. One company set the appointment standards at within 5 days for routine care, within 24 to 48 hours

for urgent care, and immediately for emergency care, but these standards did not appear in the QA plan. One company sets their standards at 2 weeks for routine care, 48 hours for urgent care, and immediately or less than 24 hours for emergency care. This was outlined in detail in a chart in their written answers, but did not appear in their QA plan. One company outlined these standards in detail in their QA plan: 4 to 8 weeks for routine care, 24 to 48 hours for urgent care, and immediately for emergency care. Two companies had the following standards: 2 weeks for routine care, 24 hours for urgent care, and immediately for emergency care. Both companies reported these standards in their QA plan. One company had a standard of 12-16 days for routine care and the next working day for urgent care, but this was not found in the QA plan. One company has a standard of within 3 days for a non-urgent appointment and within the same day for urgent visits; this information could not be verified because the company did not submit a current QA plan. One company used the standards of 12 weeks for routine care, 24 hours for urgent care, and immediate access for emergency care.

Comments: Information concerning access to providers is mentioned in all QA plans, but specific information is not always detailed. The definition of routine care was not always constant: some companies define routine care as non-symptomatic, non-emergency care (such as physicals), while others define it as symptomatic, non-urgent care. This can probably explain the wide variation in standards.

c. What are the standards regarding PCP access? (e.g., ratio of PCPs to members; travel times; closed panels) Does the plan offer any incentives to PCPs to keep their panels open to new members? Are there any other incentives to improve access?

One company has a ratio set at 1500 patients per PCP and 500 patients per licensed physician extender. They also have standards for PCP access of 2 PCPs within 10 miles; one physician within 30 miles; and one hospital within 30 miles. One company had a ratio of 97 patients per PCP, but stated their goal is 250 patients per PCP. This plan also maintains a standard of one PCP within 30 miles. One company divides their geographic distributions into urban, suburban, and rural with different access goals for each. They do have a set ratio of 1 PCP per 250 members for each geographic region. In addition, they have goals for number of PCPs with open panels (90%) and choice of PCPs (members have a choice of 3 PCPs in their region). Two companies reported that 85% of members must have a choice of at least two PCPs within 8 miles of their residence in urban areas, fifteen miles in non-urban areas, and thirty miles in rural areas; provider to patient ratios were not given. One company noted that their providers or designees should be available 24 hours a day/seven days a week for emergency care and that patients with scheduled appointments should not wait more than 30 minutes, but did not give specific patient ratios. One company requires that their PCPs accept 250 members into their practice, and stated that all members must be able to reach a PCP within 20 minutes driving and a hospital within 30 minutes driving. One company has an access standard of at least one PCP within 30 minutes for both urban and rural members. One company did not give specific standards, but did note that access has not been a problem according to member surveys.

One company does not offer incentives to PCPs to keep their panels open, but closure is not allowed for panels with less than 250 members. One company pays additional fees to PCPs if the practice is open to new members; if access issues arise, the provider may be subject to reduced reimbursement or it may be considered during the recredentialing process. One company uses an incentive program to keep panels open. One company offers incentives to PCPs who have open panels and extended office hours, and also continues to recruit PCPs in geographic areas that do not meet their standards for access. One company gives special payments to offices open to new members that increase the base capitation rate. Four companies do not offer incentives, but one of these companies does give PCPs quarterly bonuses for having an open panel and extended office hours.

Comments: Some standards are documented in the QA plan for three companies. Five companies did not mention these standards in their plan at all, and one company described activities to improve access in their QA work plan but did not give specific targets or current policies. Information could not be verified for the plan that did not provide their QA plan. Most companies use GEOAccess to track PCP coverage. It should be noted that some companies might have reported minimum PCP to patient ratios, which are business decisions, rather than maximum ratios, which could be quality indicators.

d. Is the formulary binding or advisory?

Five companies state that their formulary is advisory. The formulary is binding in two companies. One company did not answer this question, and it was not documented in their QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

e. Which pre-certification requests CANNOT be done on the phone, but require medical record review?

One company reports that no pre-certification requests can be done on the phone. One company stated that all pre-certifications can be done on the phone except those that require x-rays or dental and cosmetic procedures. Three companies stated that generally all pre-certification requests can be done on the phone unless additional information is required for the decision. One company reported that all pre-certification is done by faxing a referral request form and including medical information. One company did not answer this question.

The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company allows the PCP to determine medical necessity for all procedures except cosmetic conditions and transplants, which require medical record review; this information was found in the QA plan.

Comments: This type of information is not required to be in the QA plan.

f. How is PCP bonus or withhold affected when a patient exercises his POS option vs. when the referral is to an in-network provider?

Six companies reported that PCP bonus or withhold is not affected when a patient exercises his POS option. One company did not answer this question, and no standards were found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

One company mentioned in their QA plan that there is no withhold when a patient exercises the POS option, but there are penalties if the PCP refers a patient outside of the network.

Comments: This type of information is not required to be in the QA plan.

g. Does the HMO have standards for response time to providers requesting pre-authorization for services? Is there a plan for improved response times?

One company did not indicate a specific response time, but did state that determinations were made at the time of receipt of all medically necessary information. They do have a process for monitoring timeliness of response. Three companies reported that pre-authorizations are normally provided within 24 hours of receipt of all necessary information, and they all have a process for monitoring timeliness. One company stated that their standard response time is between 24 and 48 hours when all information is available. This response time increases to between 7 and 10 days when more information is required. This plan conducted a study of their response time and found that they responded within 24 to 48 hours 95% of the time. One company processes routine care requests within 2 business days, and urgent care requests within 1 business day; they have an electronic tracking system to analyze timeliness of response. No documentation was found in these six QA plans. One company did not answer this question, and no standards were found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company makes decisions within 2 business days; this information was found in the QA plan.

Comments: Only one company has this information available in detail in their QA plan.

h. Are physicians at risk for more than services provided in their offices through use of either of the following reimbursement methods?

Global Capitation: "a type of reimbursement in which an entity such as a physician-hospital organization is reimbursed a capitation amount for a particular group of members, and such entity is responsible for providing or paying for all (or most) of the covered services provided to those members by any provider."

Episode of Care reimbursement: "A provider is paid a fixed dollar amount for the treatment of a specific illness, condition, surgery or episode of care. The provider is responsible for using this fixed payment to cover all expenses related to such illness, condition, surgery or episode of care. For example, a surgical group would be responsible for using this fee to cover the hip joint surgery and related expenses such as anesthesia, radiology, hospitalization, etc."

Four companies do not use either of these methods. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company uses per diem rates in contracts with hospitals, skilled nursing facilities, subacute units, and ambulatory surgery centers. One company uses capitation for all offices services provided by its PCPs, a combination of capitation and fee-for-service for its specialists, and per diems for hospital care; in addition, certain ancillary providers are paid using fee schedules. Two companies did not respond, and this information could not be found in the QA plan.

i. What specialties are paid by capitation?

One company capitates laboratory and radiology services. Three companies do not capitate any services. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company capitates GI, physical therapy, laboratory, and radiology. One company reported that they capitate most specialty support services such as radiology, podiatry, and outpatient mental health services. Two companies did not respond, and no documentation could be found in their QA plans.

Comments: This type of information is not required to be in the QA plan.

4. Credentialing

a. What credentialing activities are identified in the plan?

All nine companies presented detailed guidelines for credentialing in their QA plans that comply with NCQA standards. Two companies specifically mention using NCQA standards. Recredentialing is conducted every two years, except one company reviews providers annually during their first two years of participation. One company's answer to the study question was much more extensive than the information presented in the QA plan. Information could not be verified for the company that did not provide their QA plan.

b. What credentialing activities are done in the interim between recredentialing?

Eight companies report that they continue to monitor their providers in terms of licenses, DEA certificates, and malpractice insurance. Also, in one company, if any adverse information is reported about any of their providers, a special review is conducted; guidelines for this special review are in the QA plan. Six of these companies also perform ongoing medical

record review and quality indicators reviews. Five of these companies described these activities in their QA plans, but information could not be verified for the company that did not provide their QA plan.

One company reviews provider files as needed; this information was outlined in the QA plan.

c. How is the HMO informed of providers whose licenses are revoked or suspended?

One company uses the National Practitioner Data Bank and utilizes reports from licensing boards and HCFA; this information was not found in the QA plan. One company has contracted with an NCQA-certified agency that informs them when any of their providers have licenses revoked or suspended. The company verifies this information and follows-up as needed. One company queries the various states where they do business to check current licensing; currently Virginia publishes this information every two years. One company receives the information directly from the State Board of Medical Examiners, but does not indicate how often that information is obtained. Two companies stated they verify all information at the time of credentialing. One company sends a service coordinator to each provider's office quarterly; they rely on the provider to inform them of licensing problems between formal credentialing periods. One company requires their providers to inform them of any actions against their license; this company also utilizes other national and state-level sources. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

Comments: Only one company has a system for prompt notification of license suspension or revocation. A provider could continue to practice for over a year before some plans learn of their license status. However, credentialing is an important part of all nine company QA plans.

5. Consumer Satisfaction

a. What activities does the plan describe to assess consumer satisfaction?

One company has been doing consumer surveys for ten years, using the GHAA survey until 1996, when they started using NCQA's HEDIS member satisfaction survey. This company also does routine group-specific surveys and disenrollment surveys. Focus groups with members and providers are being established. All of this information was mentioned in a less detailed format in the QA plan.

Five companies perform several annual surveys, including a member satisfaction survey and a disenrollment survey. This information was outlined without much detail in the QA plan for four of these companies, and could not be verified for the company that did not submit their QA plan. One company utilizes the Gallup organization for annual surveys. One company incorporates 60% of the NCQA survey's questions for their annual survey. Five companies use the entire HEDIS member satisfaction survey. One company did not answer this question, but their QA plan describes ongoing surveys to assess consumer satisfaction.

Comments: Measurement of customer satisfaction, an NCQA requirement, happens in all plans in one form or another. Standardization of satisfaction surveys will increase the utility of the results across plans.

b. If a survey is undertaken, what does the HMO do to ensure scientific validity and reliability of the instrument?

The five companies who currently use the HEDIS survey use HEDIS measurement guidelines. These companies outsource additional satisfaction surveys to a survey company. Two of these five companies also developed internal surveys that are reviewed annually by internal staff. One plan works with their outside vendor to ensure validity and reliability; this information is not detailed in the QA plan. One company sends out annual satisfaction surveys to a majority of their members, but this information could not be verified because they did not provide their QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions or for the company that didn't answer the question.

c. What activities are identified by the plan that address UR denial and appeals?

Six companies routinely analyze their UR denial and appeals data for trends and address problems as they arise. Recent areas of member concern led to the initiation of review groups for one company. This information was not specifically mentioned in the QA plan, but provisions for periodic review of all plan data are outlined.

Two companies send information about how to appeal to all enrollees in their Certificate of Coverage, but did not mention if they specifically track UR denial and appeals. One company did not answer this question, but their QA plan shows routine collection of UR information.

Comments: This question might have been ambiguous. Most plans track UR denial and appeals, but it was not clear if they looked at this issue in terms of customer satisfaction with the appeals process.

d. How does the HMO comply with §38.2-4304.B? ("The governing body [of the HMO] shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (I) the establishment of advisory panels, (II) the use of advisory referenda on major policy decisions, or (III) the use of other mechanisms.")

Two companies have established a Member Advisory Committee. One company has established an enrollee focus group and solicits enrollee feedback at enrollment sites. One company does not have a formal advisory group, but does have consumer representation on their Board of Directors, uses focus groups, and solicits comments through mailed surveys. One company has consumer membership on their governing board, focus groups, and consumer

participation on their grievance committee. Another company uses both member surveys and Client Advisory Forums. One company solicits member feedback only through an annual satisfaction survey. One company did not answer this question, and the answer was not found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

Comments: Plans have complied with this regulation, but it is often unclear how enrollees are chosen to serve on advisory committees or what impact their views have on company policy.

e. Do members receive physician-specific performance information such as "report cards"?

Seven companies report that they do not send members physician-specific performance information. One company (NYL) did report that names of providers who receive awards for excellence are named in the member newsletter, and one company noted that they do not send this information to members because they don't want this information used in a punitive manner.

One company provides report cards on primary care offices to their members upon request. The answer to this question was not documented in the QA plan for the plan that did not return the study questions.

Comments: Physician-level data are not often released from any insurance plan because it is difficult to adjust for all risk factors that might affect the way a particular provider practices. For example, Virginia Health Information is currently working on a study that will provide physician-specific data for obstetricians in the Commonwealth; many parties are concerned that some providers will be unfairly represented by these data.

f. Are physician satisfaction surveys undertaken? If so, how are they conducted? What is done with the results?

One company stated that they conduct provider satisfaction surveys every six months by mail. The results of the surveys are kept internally to help identify problems. One company conducted a single telephone survey of randomly selected providers; these data were kept internally for strategic planning purposes. One company contracts with an outside vendor to perform the survey every 1 to 2 years using internally developed instruments; results are used to help improve services. One company conducts an annual provider satisfaction survey and quarterly PCP turnover rate reviews; the information is used internally to improve performance. Three companies conduct annual surveys that are also used internally. One company has not conducted any provider surveys. One company reported doing patient satisfaction surveys that focus on patient satisfaction with their providers, but it was noted in their QA plan that they also conducted provider surveys. All but one company mentioned doing provider satisfaction surveys in their QA plan.

Comments: Only one plan reported not doing any provider satisfaction surveys.

g. Does the provider relations department track provider complaints and concerns? How?

Four companies have a provider relations department that tracks provider complaints and concerns through an automated system. One company utilizes their regular customer service department but flags provider complaints for later analysis. This was not documented in the QA plans. One company uses the customer log system described in their grievance procedures, but they did not elaborate how they separate provider complaints from enrollee complaints. One company is currently initiating a special online tracking system for all provider calls. The answer to this question was not documented in the QA plan for the company that did not return the study questions and for the company that did not respond to this question.

6. Improvement of Community Health

a. What focused studies are identified in the goals and objectives of the plan (i.e., disease-specific, population specific)? Are methodologies identified?

Five companies mentioned several focused studies that were both disease-specific (diabetes) and population-specific (Medicare). These studies and methodologies are outlined in the QA work plan for three companies, one company reported that methodologies were not in their QA plan, and information could not be verified for the company that did not submit their QA plan.

One company reported that they are revising all of their focused study programs in order to meet NCQA standards, so they could not provide details. One company described their ambulatory medical record review as a way to measure quality of care standards, but did not mention any specific focused studies. One company did not answer this question, but their QA work plan describes multiple outcome studies. One company described utilization studies based on diagnosis, but methodologies were not found in the QA plan.

b. What provisions does the plan make for feedback to providers concerning QA activities in general and specific outcomes of care in particular?

One company contracts with an outside agency to perform continuous assessments and reports these assessments to their providers on a monthly and annual basis, but this information could not be verified because they did not provide their QA plan. One company uses their physician relations department to disseminate this information through a printed and online newsletter. Feedback is encouraged through both media.

Four companies distribute a newsletter, send direct letters to providers, and present educational programs. Two of these companies had these procedures set out in detail in the QA work plan, while the other two companies mentioned these activities without detail.

One company did not outline their provisions in their QA plan, but stated that they send letters with specific concerns to the involved provider, distribute a newsletter to all

providers, and send out periodic mailings on specific topics. One company did not respond to this question, but an examination of their QA plan showed that communicating the results to practitioners and members is one of the objectives of the quality improvement process. The answer to this question could not be determined for the company that did not provide survey answers, but the QA plan does mention quality monitoring and feedback to regional offices.

7. Outcome Measures

What activities does the plan indicate will be initiated to address poor clinical outcomes such as death, readmission to the hospital, hospitalization following ambulatory surgery, unscheduled return to the O.R., post-op infections?

Eight companies track poor clinical outcomes (readmissions to hospitals, emergency room visits after physician office visits, outcomes after adverse decisions, mortality) and analyze these data on a regular basis. Action is taken on all quality concerns, including conferencing with providers. Two companies have also undertaken focused studies on certain adverse clinical outcomes, such as readmissions.

This process is outlined in the QA work plan of five of the eight companies. One company did not respond to this question, but an examination of their QA plan revealed specific plans to address unplanned readmissions after adverse decisions and admissions after ambulatory surgery. One company had a very detailed answer to the study question, but had no documentation in their QA plan. One company did not have any of this information in their QA plan. Information could not be verified for the company that did not provide their QA plan.

The answer to this question was not documented in the QA plan for the company that did not return the study questions, but they did report overall tracking measures.

Conclusions: The QA plans for the companies that responded to our requests were fairly complete and relatively easy to read, but what constitutes a QA plan in one company does not always correspond to the QA plan of another company. For instance, one company sent a QA plan that was approximately 1000 pages in length that included all internal and external QA policies. In contrast, one company had a QA plan that was 14 pages in length. There were many instances where detail, such as the target times for patient appointments, was not documented. Also, grievance procedures were often separate from the QA plan, not included as a part of the overall plan. We did not visit any of these sites, nor did we look at all the materials that an organization such as NCQA would during an accreditation visit. We could only analyze the information that was provided to us by these companies, which might not have always been complete.

APPENDIX D

ANALYSIS OF HMO GRIEVANCE PROCEDURES

Appendix D: Analysis of Grievance Procedures - HMOs

Methodology

At the commencement of the study, all grievance procedures from HMOs licensed in the Commonwealth on file with the Bureau of Insurance were copied and sent to the Department of Health Evaluation Sciences at the University of Virginia. Researchers answered the questions contained in the analytical frameworks based on these documents. Interviews with the person or people deemed most responsible for these plans were arranged to go over the lists of questions for clarification. After three interviews with HMO representatives, it was determined that the documents received at DHES from the Bureau of Insurance were not the most current grievance procedures. In order to rectify this problem, the study methodology was changed slightly, allowing the HMOs to present their current plans. A tracking chart listing the HMOs and the status of their submissions follows the analysis of the grievance plans in this Appendix.

Based on several descriptive factors, a representative sample of HMOs licensed inVirginia was chosen for inclusion in the study. These factors included age of the plan, geographic region of service area, status of NCQA accreditation, number of total members and number of Virginia members, state of domicile, and tax-status. A total of seventeen (17) HMOs were chosen. In some cases, more than one plan from a particular company was chosen in order to make comparisons within companies. Contact information for each HMO was obtained from the Virginia HMO Association.

A research assistant initiated contact with the people deemed most responsible for grievance procedures at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to grievance procedures. Each plan was instructed to complete the questions with relevant citations noted and to send current grievance procedures to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study.

The following HMOs were contacted regarding their grievance procedures: Aetna, Cigna-MidAtlantic, Cigna-Virginia, HealthKeepers, HMO Virginia, John Deere, MD-IPA, NYLCare, Optima, Optimum Choice, Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), QualChoice, Sentara, US Healthcare (now part of Aetna), and Virginia Chartered. Virginia Chartered was dropped from the study because no person able to respond to the questions could

be reached within the study time frame. Responses were received from John Deere, MD-IPA, NYLCare, Optimum Choice, HMO Virginia, HealthKeepers, Aetna/United Healthcare, QualChoice, Partners, Prudential-MidAtlantic, and Prudential-Richmond (PruCare).

Once the documentation and completed questionnaires were received at DHES, the researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions. Grievance procedures were compared to two national standards for utilization management: National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission/URAC.

Analysis

Grievance Procedures

Twelve HMOs returned the completed questionnaire concerning their grievance procedures. One HMO did not return the completed questionnaire but did provide documentation of their procedures, so analysis was done on the information available. One company did not submit current grievance procedures, so answers could not be verified. The response rate, including the plan that only provided their grievance procedures, was 81%, and it can be reasonably assumed that these thirteen HMOs may be deemed a representative sample of all HMOs in the Commonwealth. Three companies, Aetna (which owns United Healthcare), Trigon (HMO Virginia and HealthKeepers) and MAMSI (MD-IPA and Optimum Choice), use the same grievance procedures for all their HMO products. Therefore, analysis was done on the grievance procedures submitted by each company rather than each plan, resulting in a total of nine sets of grievance procedures. Certain patterns in these grievance procedures emerged that merit consideration. Each question in the analytical framework has been answered using responses from the companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each company. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF HMO GRIEVANCE PROCEDURES

1. How does the plan member know about the grievance procedure?

Six companies reported that grievance procedures were outlined in their member handbook. Three companies distributed this information in a publication entitled "The Evidence of Coverage," which could be deemed a member handbook. Four companies presented information in more than one publication.

Comments: This information is very important and should be available to all members and providers in an easily understood format. This question did not address all the ways a member might receive this information, such as when a member calls with a complaint or question.

2. How many days does the plan member have after denial to ask for reconsideration?

The range for eight companies was from within 10 days to within a year, with three companies reporting 60 days. One of these companies noted that the time limit depends on the level of appeal. One company stated that they had no time limit restrictions.

Comments: This information was not explicitly stated in two of the companies' grievance procedures, but all plans gave this information to members in the member handbook. There is a concern that there might not always be enough time for the member to realize there is a problem. In the case of one company, a member only has ten days to request a reconsideration of a grievance and thirty days to file a formal complaint.

3. Who makes the first attempt to resolve the complaint?

One company encourages their members to contact their provider about medical treatment concerns before calling the plan itself. All companies have a member services or customer services department that handles calls directly from enrollees or provides an address to send written complaints. In one company, the type of complaint, written or oral, affects which department within the plan handles it. Another company stated that their goal is to have the complaint resolved informally.

Comments: It should be noted that "complaint" was viewed both as a regular complaint and as an appeal. This led to some confusion on the part of the respondents.

4. How many days does the HMO have to respond with a decision?

All companies have the policy of resolving complaints within 30 days of receipt. Response to appeals are usually shorter (within 10 days).

Comments: Again, some of the respondents did not know whether this question referred to a regular complaint or an appeal.

5. Do plan members have access to the names of members of the review panel?

One company does not allow members to have access to the review panel; there is a Grievance Coordinator who signs the letter of denial, which contains further appeal instructions. One company reported that members do not have access to the names of review panel members

except when the member requests to meet in-person with the whole panel. Five companies would allow access to the names of the review panel upon request from the plan member. One company explained that access to review panel members depended on the level and type of appeal or complaint; they stated that "consideration would be given" about disclosing names upon request of the member, but in certain cases (such as in the use of medical specialist consultants in reconsiderations), the names of the reviewers are not disclosed. One company chose not to respond to this question.

Comments: Review panels often change depending on the type of complaint (medical or administrative) and level of complaint. As seen in Question 23, the number and qualifications of the people on the panel changes significantly depending upon these factors.

6. Describe the first level of a formal appeal.

For all companies but one, formal appeals must be submitted in writing to the plan. Senior staff are involved in the appeals process at this stage. The decision may be made by an individual, such as the Medical Director (one company) or the Operations Manager (one company), or by an appeals committee (six companies). One company differentiates between a regular appeal and appeals that involve medical decisions; for the latter, all appeals must go through the Grievance Procedures.

7. How many days does the HMO have to respond?

This ranges between within 30 days and within 60 days.

Comments: The plans were assuming that this question referred specifically to response to a first level appeal. It should also be noted that neither NCQA nor URAC have exact standards about timeliness of response to appeals, except for the provision of expedited appeals. According to NCQA, by 1998 managed care organizations must meet specified industry standards for timeliness. Chapter 54 states that a person must be notified of the results of the appeal process no later than 60 working days after the HMO receives the required documentation.

8. Is there a second level appeal?

All companies that responded have second level appeals. This appeal must be in writing.

9. Does the plan member have a right to appear before the panel?

All plan members have the right to appear before a review panel if they request.

10. Is there a third level appeal?

One company allows their members to write a final letter of appeal to the President of the HMO. One company stated explicitly that a third level of appeal, arbitration, was available to plan members. One company mentioned the option of filing an appeal with a government agency such as the Bureau of Insurance, but noted that this was not a formal policy. The remaining companies answered no to this question.

Comments: All enrollees have the right to appeal to government agencies such as the Bureau of Insurance or HCFA, but most plans do not mention this in their member information.

11. Does the HMO have expedited appeal?

All companies have expedited appeals, but the time allowed for a decision ranges from 24 to 72 hours. One company referenced HB1973 of the Commonwealth of Virginia Statutes. One company urges the member to call them directly in case of emergency or urgent circumstances.

Comments: A process for expedited appeals is required by NCQA, URAC, and Virginia law. Both NCQA and URAC require that appeals be resolved within 72 hours.

12. Can the plan member complain orally?

All companies allow members to complain orally or in writing. Formal appeals must be in writing for eight of the nine companies.

Comments: There are again problems with definitions about what a complaint is. In one plan, oral complaints that can be handled over the phone are not recorded. In some plans, a complaint must be in writing for it to go through the appeals process. See Question 14.

13. Are there accommodations for non-English speakers and the handicapped?

Five companies mentioned specifically that they either contract with or have access to interpreters. Four companies reported that they made provisions for these populations, but were not specific. No companies had this information in their grievance procedures.

Comments: This information is often not contained in the member handbooks. "Access to interpreters" was not defined. Some members might have to wait for an interpreter to be contacted before their complaints or concerns can be conveyed to a plan.

14. What happens when a member calls with a complaint or concern?

All companies send these calls to the member services or customer services department. This information is available in all the grievance procedures, but the process in not always explicitly stated. One company allows for verbal complaints as well as suggesting sending the

complaint in writing to the plan. One company differentiates between informal complaints and concerns and complaints regarding a denial of benefits or services. The latter type must always be sent to the plan in writing, and callers are informed of this. Another company sends all complaints and concerns about providers received by phone directly to the quality improvement department, even if the complaint is resolved at the time of the initial call; other complaints are recorded verbally. Two companies state that resolution is attempted on the phone, and a complaint form is sent to the caller if he is not satisfied with the result. Two companies attempt to have their member services department handle all calls. One company allows members to file formal grievances over the phone; the customer services representative forwards the information to the grievance committee. One company did not elaborate.

Comments: The process of making a complaint is complicated and not always explained in easy terms to the plan member. Most of the member handbooks tell the enrollee to call the member services or customer services department with any concerns. It is up to the person receiving the call to help the caller progress through the system.

15. Is there a tracking system?

All companies reported that they utilize tracking systems for complaints and referenced them in their grievance procedures. Two companies only document complaints that cannot be resolved verbally on the phone. One company keeps a customer log for all phone inquiries and a complaint log for all written complaints. Five companies record all complaints, whether they are registered in writing or on the phone. One company did not elaborate about their tracking systems.

Comments: Again we saw a problem in the use of the term "complaint." The plan that differentiates between inquiries and complaints did not define those terms explicitly in their grievance procedures. This problem was consistent in all the plans. There is also some concern about the two companies that only record complaints that cannot be resolved on the phone; no effort is being made to track what these complaints entail.

16. Are complaints made through the Bureau of Insurance tracked separately?

Eight companies reported that these complaints are tracked separately. One company does not track them separately.

17. Is there anything unusual about the definition of a complaint?

One company reported that there was nothing unusual about the definition of a complaint, but a complaint was not defined specifically in their grievance procedures. One company states that there isn't anything unusual about the definition of a complaint. However, their grievance procedures mention the differences between an inquiry or problem and a complaint. They do not

give an explicit definition of any of these terms. One company did not give any definition of this term in its procedures or make a distinction between a complaint or any other type of grievance. Another company defined a complaint as "an oral or written expression of concern about the Plan or Plan providers." This definition was explicitly stated in their grievance procedures. One company defined a complaint as "a criticism or expression of dissatisfaction by a member," but this definition did not appear in their grievance procedures. One company made a distinction between a complaint (written or verbal expression of dissatisfaction) and a grievance (written expressions of dissatisfaction, usually a request for a decision reversal). These definitions did not appear in the grievance procedures or member handbook. Two other companies make a distinction between complaints (informal) and grievances (formal process). Finally, one company did report that a complaint differs from an appeal in that it is considered to be an expression of dissatisfaction regarding an administrative issue. Appeals are requests for reconsideration of an adverse decision.

Comments: Part of the problem with the answers to this question is with the ambiguity of the term "complaint." What we were trying to see was whether or not the HMOs differentiated between a complaint, an inquiry, and a formal grievance. It was determined through a reading of the companies' grievance procedures that definitions of these terms are not always clear.

18. If the HMO subcontracts with a managed mental health company, who handles complaints?

Three companies with subcontracted managed mental health services reported that members could utilize either the subcontractor's complaint procedures or the HMO's; complaints are registered with the primary HMO, regardless of where the initial complaint is made. Two companies handle all complaints, but one involves the subcontractor in clinical decisions and one has a special division dedicated to mental health concerns. All appeals for these companies must be made to the HMO, not the subcontractor. Two companies did not answer this question. Two companies do not subcontract for managed mental health services.

Comments: The complaint process is more complicated when an HMO subcontracts with another company to provide services. Members are encouraged to call the primary HMO, but they are not required to do so.

19. What is the basis for deciding medical necessity?

One company uses the definition of medical necessity as "services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an illness or injury as determined by the Plans." This definition appears in the member handbook, but not explicitly in the grievance procedures. Another company allows the Medical Director to make the determination of medical necessity

based on certain criteria described in the grievance procedures. This company goes on to say that "The fact that a service is prescribed or recommended by a physician or other health care provider does not mean that the service is medically necessary or that it is a service covered under the Certificate." One company uses specific criteria from Milliman and Robertson and InterQual ISD/SIMs, but this information is not detailed in their grievance procedures. One company uses Milliman and Robertson and ISSI, and they also make use of internally developed protocols and guidelines. Another company mentions the use of medical record review and the application of nationally recognized criteria, but does not mention specific criteria. This company does state that if criteria are not met, the case is reviewed by a peer with similar training and background as the involved provider. One company did not define medical necessity, but it did mention that if an appeal is denied based on medical necessity, peer review would be conducted. One company stated that the HMO determines medical necessity, but does not elaborate on who makes these decisions. One company has the network provider determine medical necessity; if care is received out of network, the Medical Director and medical services department makes determinations. One company did not respond to this question.

Comments: The criteria for determining medical necessity should be explicit and shouldn't change no matter what the level of appeal is or who is actually determining medical necessity. Criteria are not described in detail in any of the companies' grievance procedures.

20. How are Medicaid grievances handled? Medicare? Federal Employees Health Benefit Plan (FEHBP)? Are grievance procedures different for these groups?

Three companies handle Medicaid enrollees; two companies use the same grievance procedures as with regular enrollees while one company utilizes the guidelines given by HCFA. For Medicare, four companies use the guidelines recommended by HCFA, two companies use the regular grievance process for informal and first level appeals but send second level appeals directly to HCFA, and three companies do not serve Medicare enrollees. For FEHBP, seven companies use the same grievance procedures as with regular enrollees with the stipulation that an enrollee can appeal to the Office of Personnel Management after a denial at the HMO level, one company uses specific FEHBP policies, and one company does not specify whether they handle enrollees in this type of plan.

Comments: Overall, grievance procedures are not significantly different for these groups (Medicaid, Medicare, FEHBP), but these enrollees are able to go to different agencies for higher level appeals. The information concerning Medicare was specifically mentioned in two companies' formal grievance procedures. These two companies did not reference the special appeals agencies available to Medicaid and FEHBP enrollees, but this information was available in their member handbooks.

21. Does the grievance procedure reference Chapter 54 of Title 38.2 of the Code of Virginia? Are the procedures commensurate with Chapter 54?

No companies reference Chapter 54 specifically. Five companies reported that their procedures were commensurate with Chapter 54. One of these companies reported that "the average enrollee would not have ready access to the code."

Comments: Chapter 54 was passed in 1995 and its processes have not been used very often, which might explain why no specific references were found.

22. May a provider acting on behalf of an enrollee initiate a grievance?

Seven companies allowed for this process within their regular grievance procedures. One company had a special process for physician appeals. One company allows this only when the provider has written authorization from the member.

23. What are the positions and titles of the HMO review committee that decides grievances?

All companies mention the use of a review committee, but they differ on how much detail is given in their grievance procedures. One company uses a quality improvement task force as its complaint appeals panel; this panel includes the chief medical officer and several senior staff in the plan. Denial determination appeals make use of peer review members, and this information is stated in the grievance procedures. One company uses the Operations Manager in consultation with the Medical Director for first level appeals. At the second level, a Local Grievance Committee, made up of five members - none with medical degrees. Another company has an Appeals Committee consisting of the Medical Director, Medical Services Director, and the Customer Services Director. These individuals must not have been involved in prior decisions in the case, and at least one must be certified, licensed, or skilled in the same health care category as the provider involved in the dispute. These individuals can also appoint "similarly qualified designees." One company uses a committee made up of internal and external reviewers; currently four members of this panel have medical degrees. One company has a team of six, four of whom have medical degrees. One company uses a team consisting of a supervisor, a registered nurse, the Medical Director, and the Grievance Coordinator. One company has a Grievance Committee and an Appeals Committee, each with different membership; the Medical Director and the CEO sit on the Appeals committee. One company did not elaborate about the Local Appeal Committee used for level 1 appeals or the Operational Appeals Committee used for level 2 appeals, but the Medical Director is involved in both processes. One company chose not to answer this question.

Conclusions

The most striking finding from the above analysis is the lack of consistency in the definitions of many terms, including inquiries, complaints, and grievances. Our study questions reflected this confusion and resulted in multiple and qualified answers to the same question. There are also many variants in the grievance process, ranging from informal oral processes to

formal written processes. Information that is found in membership handbooks is often not found in the plan's official grievance procedures and vice versa. Official grievance procedures are not always given to plan members and providers, leading to confusion about where to start the process and how to navigate the process in general.

NAME OF HMO	*ORIGINAL QA PLAN*	*ORIGINAL GP PLAN*	*LATEST QA PLAN*	*LATEST GP PLAN*
* NYL CARE HEALTH	1996	No year provided	Selected/ Provided 1997	Selected/ Provided 1997
* OPTIMA	1994	1995	Selected/ Not Provided	Selected/ Not Provided
*MAMSI: OPTIMUM CHOICE	1990	1995	Selected/ Provided 1996	Selected/ Provided 1996
HUMANA GROUP	No date indicated	1992	Not Selected	Not Selected
* KAISER FOUNDATION MID.ATLANTIC	No QA provided	Revised in 1993	Not Selected	Not Selected
NATIONAL CAPITAL	No date indicated	No date indicated	Not Selected	Not Selected
* MD INDIVIDUAL PRACTICE	1994	1995	Selected/ Provided	Selected/ Provided
HERITAGE NATIONAL	1993	1993	Not Selected	Not Selected
* HMO VIRGINIA	No date indicated	1996	Selected/ Not Provided	Selected/ Not Provided
HEALTH FIRST & PRIORITY HEALTH	1994	No date indicated	Not Selected	Not Selected
* HEALTH KEEPERS	No date indicated	1996	Selected/ Not Provided	Selected Not Provided
HMO PLUS	No date indicated	1996	Not Selected	Not Selected
*QUAL CHOICE	No date indicated	1995	Selected/ Provided 1996	Selected/ Provided 1995
*PRUDENTIAL	1982	No date indicated	Selected Provided 1997	Selected Provided 1997
PRINCIPAL HEALTH CARE	Not date indicated	No date Indicated	Not Selected	Not Selected

NAME OF HMO	*ORIGINAL QA PLAN*	*ORIGINAL GP PLAN*	*LATEST QA PLAN*	*LATEST GP PLAN*
PHYSICIANS HEALTH PLAN	1983	No date indicated	Not Selected	Not Selected
PHN-HMO	1996	1996	Not Selected	Not Selected
PENINSULA HEALTH CARE	1996	None provided	Not Selected	Not Selected
* PARTNERS	1996	1996	Selected Provided 1997	Selected Provided 1997
* SENTARA	1994	1995	Selected Not Provided	Selected Not Provided
SOUTHERN HEALTH	1995	Revised 10/95	Not Selected	Not Selected
UNITED OPTICAL OF VA	No date indicated	None provided	Not Selected	Not Selected
US HEALTHCARE	1993	No date indicated	Selected Not Provided	Selected Not Provided
* VIRGINIA CHARTERED	No date indicated	No date indicated	Selected Not Provided	Selected Not Provided
* AETNA	1991	1996	Selected Not Provided	Selected Not Provided
CAPITAL AREA PERMANENTE	1981	None provided	Not Selected	Not Selected
CAPITAL CARE	No date indicated	1996	Not Selected	Not Selected
CHESAPEAKE	1995	No date indicated	Not Selected	Not Selected
CIGNA-MID-ATLANTIC	1994	1993	Not Selected	Not Selected
* CIGNA OF VA.	None provided	1995	Selected Not Provided	Selected Not Provided
COMM. PLANS, INC.	None provided	None provided	Not Selected	Not Selected
EQUICOR	No date indicated	None provided	Not Selected	Not Selected
GEORGE WASHINGTON UNIVERSITY	No date indicated	1995	Not Selected	Not Selected
* JOHN DEERE	1996	Not provided	Selected Provided 1996	Selected Provided 1996

APPENDIX E

ANALYSIS OF QUALITY ASSURANCE PLANS - CORPORATIONS OTHER THAN HMOs

Appendix E: Analysis of Quality Assurance Plans - Corporations Other Than HMOs

Methodology

In order to make comparisons about the quality assurance plans in HMOs and other corporations, a sample of corporations with indemnity plans was generated by the Bureau of Insurance, State Corporation Commission. A total of twenty-one (21) companies, representing the highest volume of policies, were chosen. Each company CEO was faxed a letter from Randolph Gordon, Commissioner of Health, asking for their participation in this study and requesting contact information. This information was compiled by the Virginia Department of Health and forwarded to the Department of Health Evaluation Sciences at the University of Virginia. Contact information was received for fifteen (15) companies.

As was done with the HMOs, a research assistant initiated contact with the people deemed most responsible for QA plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the quality assurance plans. Each plan was instructed to complete the questions with relevant citations noted and to send current QA plans to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study. Specific references to HMOs were stricken from the sets of questions sent to non-HMO companies.

The following companies were contacted regarding their QA plans: Prudential, Mutual of Omaha, Employees Health Insurance, Trigon Blue Cross Blue Shield, AFLAC, The Guardian, Mass Mutual, UNUM, Principal Mutual Life, Portis, New York Life, State Farm Mutual Auto, Continental Assurance Company, Aetna, and Combined Insurance Company. Full responses were received from Mutual of Omaha, Employees Health Insurance, and Trigon. State Farm Mutual Auto, AFLAC, UNUM, and Combined Insurance Company reported that they do not have any managed care products and therefore did not have quality assurance plans or grievance procedures as defined in this study. Mass Mutual was dropped from the study because it had been sold twice and no appropriate person could be contacted during the study period. A tracking chart listing the plans and the status of their submissions follows the analysis of the grievance plans in Appendix F.

Once the documentation and completed questionnaires were received at DHES, the researchers examined the answers and citations for completeness, accuracy, and clarity. Any

questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions.

Analysis

Three non-HMO plans responded to our questions. Each question in the analytical framework has been answered using responses from all three plans, followed by comments from the researchers in some cases. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each plan. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF INDEMNITY (non-HMO) QUALITY ASSURANCE PLANS

1. Prevention

a. Identify the QA plan's goals and objectives that address preventive care. Name, if applicable, specific HEDIS measures that will be undertaken (e.g. cholesterol screening, diabetic retinopathy exam, mammography recommendation, etc.). If HEDIS measures are planned, describe what efforts the plan is making to ensure valid and reliable encounter data.

One plan gave a very detailed answer to the study question, but these activities were not documented in their QA plan. They mentioned using HEDIS measures, but did not specify which. Two plans stated that they don't use HEDIS measures, but they do have other programs in place to address preventive care. This process was well-documented in one plan's QA plan, but not mentioned in the other.

Comments: Many PPO plans do not try for NCQA accreditation, so many companies with these plans do not implement HEDIS measurements.

b. Are prevention guidelines developed by the company or does the plan make reference to national practice guidelines? How?

One plan does not currently have prevention or practice guidelines, but they have participated in NCQA's Report Card Pilot Project to help determine levels of preventive care received by their members. One plan utilized the HCFA Case Management Program as the base in the internal development of practice guidelines. Reference to this was not found in the QA plan. One plan endorses national prevention and practice guidelines which are customized for regional practice variation. This process and specific references were not described in the QA plan.

c. Are there indications in the plan that guidelines for preventive care are shared with providers or that provider input was solicited?

One plan has shared the results of formal studies with appropriate providers, but this was not documented in the QA plan. One plan has involved several providers in a pilot prevention project, but this was not in their QA plan. Guidelines for one plan were developed using advisory panels, and they are distributed to all providers through a newsletter; this was documented in the QA plan.

2. Complaint Resolution

a. What provisions does the plan make for aggregation and analysis of complaints and grievances?

One plan tracks and analyzes all complaints and reports statistics quarterly. One plan has an online system for tracking. One plan uses a large database to record all complaints for later analysis. This information was found in all three QA plans.

b. What is the physician's office told with respect to appealing a denial for service? Are they given the name and number of the medical director? Is there a physician/provider helpline?

One plan notifies the physician in case of a denial, and the physician is allowed to appeal. In this case, the physician reviewer contacts the involved physician personally. They use their regular customer service department for standard questions, but there is a separate number for physicians involved in appeals. The process was mentioned in the QA plan, but not in detail.

One plan has a special department that helps physicians. The name of the medical director is given to the physician at the time they are informed of the denial. The process is well-documented in the QA plan.

One plan uses their standard appeals process that does not make specific reference to providers.

c. What provisions does the plan make for systematic follow-up and corrective action on identified problems?

All three plans have guidelines for follow-up of problems that depend on the type of problem. This was not stated explicitly in any of the QA plans. Their tracking systems allow them to analyze trends.

3. Access and Availability

a. What activities does the plan describe for monitoring access and availability?

One plan uses a computer program to track network access on a quarterly basis; standards vary depending on population density. One plan answered this question in relation to availability of staff at the plan, not providers; they maintain open hotlines 24 hours per day/7 days per week.

No staffing ratios were noted in their QA plan. One plan reported that this question was not applicable to them.

b. What are the standards for appointment availability for routine, urgent, and emergency care?

One plan put standards at 1 to 3 days for routine care, within 24 hours for urgent care, and immediately for emergency care. This was not documented in the QA plan. One plan does not monitor waiting times or time to appointment, but does track complaints about this topic. One plan reported that this question was not applicable to them.

Comments: Again, regulations about access to care are not applicable to non-HMOs, so many plans do not have standards. This doesn't necessarily mean they have long waiting times, but there is currently no mechanism to police this issue.

c. What are the standards regarding primary care physicians access (e.g. ratio of PCPs to members; travel times; closed panels)? Does the plan offer any incentives to PCPs to keep their panels open to new members? Are there any other incentives to improve access?

One plan does not maintain a PCP to member ratio for their program or monitor the number of physicians who are accepting new patients. They do not offer incentives. One plan has access standards that range from 5 in 5 miles to 2 in 30 miles, depending on geographic area and population density. They also strive to keep 97% of their practices open. These standards were not documented in their QI plans. One plan reported that this question was not applicable to them.

d. Is the formulary binding or advisory?

One plan reported that their formulary was advisory. Two plans stated this question was not applicable.

e. Which pre-certification requests CANNOT be done on the phone, but require medical record review?

One plan requires that all requests for medical rehabilitation services must include medical record review. Also, records are required for retrospective review. One plan allows all pre-certification requests to be done on the phone, but additional information may be required in some cases. For one plan, medical record review is required for certain procedures, such as transplants and cosmetic surgery, and may be required for other surgical procedures; each case is handled on its own merits. This was detailed in one company's QA plan.

f. How is PCP bonus or withhold affected when a patient exercises his POS option vs. when the referral is to an in-network provider?

One plan separated member self-referral outside the network, which does not affect PCP bonus, and provider referral outside the network, which does negatively affect the bonus. One plan stated that this does not affect PCP bonus, which is based on quality and utilization. One plan reported that this question was not applicable to them.

g. Does the plan have standards for response time to providers requesting preauthorization for services? Is there a plan for improved response times?

One plan stated that response time is within one business day of receiving all information. They also reported that they have no system for improving response times because most preauthorizations are done immediately. This was documented in the QA plan. Two plans did not include this information in their QA plans. One of these plans has a standard of completing all requests within 48 hours; they monitor this standard on a monthly basis and use the results to investigate problems. The other plan stated that their standard is 24 hours, and they currently meet this standard based on their reviews.

h. Are physicians at risk for more than services provided in their offices through use of either of the following reimbursement models?

Global Capitation: "a type of reimbursement in which an entity such as a physician-hospital organization is reimbursed a capitation amount for a particular group of members, and such entity is responsible for providing or paying for all (or most) of the covered services provided to those members by any provider."

Episode of Care reimbursement: "A provider is paid a fixed dollar amount for the treatment of a specific illness, condition, surgery or episode of care. The provider is responsible for using this fixed payment to cover all expenses related to such illness, condition, surgery, or episode of care. For example, a surgical group would be responsible for using this fee to cover the hip joint surgery and related expenses such as anesthesia, radiology, hospitalization, etc."

This was not applicable for two of the plans. One plan does not use global capitation, but they are working on a pilot program for joint replacements under episode of care reimbursement.

i. What specialties are paid by capitation?

This was not applicable for any of the plans.

4. Credentialing

a. What credentialing activities are identified in the plan?

All three plans gave detailed answers that include numerous application requirements, but

documentation was found in only two QA plans.

b. What credentialing activities are done in the interim between recredentialing?

One plan conducts annual reviews of all credentialing criteria. One plan monitors provider complaint and grievance patterns and takes corrective action if needed. One plan also performs ongoing medical record review and quality indicators reviews. One plan described these activities in their QA plan; the other two did not.

c. How is the plan informed of providers whose licenses are revoked or suspended?

One plan tracks their providers on a monthly basis and sends this information to employers, but not to all enrollees. One plan relies on the State Boards of Medicine, and one plan employs an outside service that provides updates on these matters. None of the plans mentioned this process in their QA plans.

5. Consumer Satisfaction

a. What activities does the plan describe to assess consumer satisfaction?

One plan sends out weekly patient and provider satisfaction surveys. This is not in their QA plan. Two plans send out consumer satisfaction surveys for their POS plans only, and this is documented in their QA plans.

b. If a survey is undertaken, what does the plan do to ensure scientific validity and reliability of the instrument?

Two plans use an instrument that is developed internally by a survey expert. One plan uses the NCQA survey for its POS products and an outside vendor for surveys for other indemnity products offered by the company.

c. What activities are identified by the plan that address UR denial and appeals?

One plan publishes a quarterly report with summary UR decisions by group. The other two plans have detailed UR plans that include systematic tracking of UR decisions. All three plans had this information in their QA plans.

d. Does the plan comply with Virginia Code §38.2-4304.B? ("The governing body [of the plan] shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (I) the establishment of advisory panels, (II) the use of advisory referenda on major policy decisions, or (III) the use of other mechanisms.")

One plan stated that this law does not apply to them. Two plans stated that they have

valid Virginia licenses and comply with all regulations that apply to them.

e. Do members receive physician-specific performance information such as "report cards?"

All plans stated no.

f. Are physician satisfaction surveys undertaken? If so, how are they conducted? What is done with the results?

Provider satisfaction surveys are not done in any of the three PPO plans, but satisfaction surveys are conducted in the POS plans that these three companies manage. Provider surveys with the plan are done weekly in one plan, but no surveys of satisfaction of patients with their providers are done. The results are kept internal. In the other two plans, members are surveyed about their satisfaction with their provider, and this information is reported back to the individual PCP.

g. Does the provider relations department track provider complaints and concerns? How?

Two plans reported that there is a special group that tracks provider issues. One plan uses the regular customer services department but flags provider calls. This information was documented in two of the three QA plans.

6. Improvement of Community Health

a. What focused studies are identified in the goals and objectives of the plan? (i.e., disease-specific, population-specific) Are methodologies identified?

One plan mentioned their study of asthma patients. One plan is also studying asthma and diabetes; this plan is currently expanding their disease management programs. One plan is doing a pilot study on patients with CHF to try to improve care. This information was not found in any of the QA plans.

b. What provisions does the plan make for feedback to providers concerning QA activities in general and specific outcomes of care in particular?

All three plans have feedback mechanisms to their providers through their quality assurance departments. This was not documented in the QA plans.

7. Outcome Measures

What activities does the plan indicate will be initiated to address poor clinical outcomes such as death, readmission to the hospital, hospitalization following ambulatory surgery, unscheduled return to the O.R., post-op infections?

All three plans track poor clinical outcomes (readmissions after adverse decisions, ambulatory surgery, and outpatient provider visits; mortality), but none was detailed in the QA plans. One plan did describe a specific study about asthma admissions and readmissions and how this information is shared with providers.

Conclusions: QA plans for non-HMO companies are much less extensive than those of their HMO counterparts. This can be attributed to a number of things, including decreased regulation of non-HMO companies and lessened importance of outside accreditation such as that done by the NCQA.

APPENDIX F

ANALYSIS OF GRIEVANCE PROCEDURES - CORPORATIONS OTHER THAN HMOs

Appendix F: Analysis of Grievance Procedures - Corporations Other Than HMOs

Methodology

In order to make comparisons about the grievance procedures in HMOs and other corporations, a sample of corporations with indemnity plans was generated by the Bureau of Insurance, State Corporation Commission. A total of twenty-one (21) companies, representing the highest volume of premiums, were chosen. Each company CEO was faxed a letter from Randolph Gordon, Commissioner of Health, asking for their participation in this study and requesting contact information. This information was compiled by the Virginia Department of Health and forwarded to the Department of Health Evaluation Sciences at the University of Virginia. Contact information was received for fifteen (15) companies.

As was done with the HMOs, a research assistant initiated contact with the people deemed most responsible for grievance procedures plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the grievance procedures. Each plan was instructed to complete the questions with relevant citations noted and to send current grievance procedures to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study. Specific references to HMOs were stricken from the sets of questions sent to non-HMO companies.

The following companies were contacted regarding their grievance policies and procedures: Prudential, Mutual of Omaha, Employees Health Insurance, Trigon Blue Cross Blue Shield, AFLAC, The Guardian, Mass Mutual, UNUM, Principal Mutual Life, Portis, New York Life, State Farm Mutual Auto, Continental Assurance Company, Aetna, and Combined Insurance Company. Full responses were received from Mutual of Omaha, Employees Health Insurance, Prudential-MidAtlantic, New York Life, and Trigon. State Farm Mutual Auto, AFLAC, UNUM, and Combined Insurance Company reported that they do not have any managed care products and therefore did not have grievance procedures as defined in this study. Mass Mutual was dropped from the study because it had been sold twice and no appropriate person could be contacted during the study period. A tracking chart listing the plans and the status of their submissions follows the analysis of the grievance plans in this Appendix.

Once the documentation and completed questionnaires were received at DHES, the

researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions.

Analysis

Five non-HMO companies responded to our questions. Each question in the analytical framework has been answered using responses from all four companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each plan. This has been noted where appropriate. It should be noted that "grievance procedures" was not terminology used by any of these companies; procedures appeared in many forms, including member handbooks, appeals documents, and complaint tracking plans. These documents were compared with the answers given to the study questions.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF INDEMNITY (non-HMO) GRIEVANCE PROCEDURES

1. How does the plan member know about the grievance procedures?

Two plans stated that this information was in the member handbook and the member contract. The other three plans reported that letters are sent to the patient (and in two cases to the provider and the hospital) when services are denied; these letters outline the procedures. One plan mentioned that the appeals process is also communicated verbally when a client calls.

2. How many days does the plan member have after denial to ask for reconsideration?

Four plans allow 60 days; one plan stated that reconsideration could be requested at any time. This information was not explicitly stated in the grievance procedures for four plans, but it did appear in one.

3. Who makes the first attempt to resolve the complaint?

One plan stated that any person who receives a complaint attempts to resolve it. Two plans reported that the first person involved depends upon the type of complaint, but typically a nurse reviews the case initially. One plan utilizes an appeal team, and one company has a claims office that handles all complaints. This information was outlined in all grievance procedures.

4. How many days does the plan have to respond with a decision?

One plan reported 30 days. Two plans responded that expedited complaints are resolved within one business day, and all other complaints are resolved within 10 days after receipt of all

needed information. One plan noted that standard appeals are responded to within 10 days, prospective or current appeals within 1 or 2 days, and claims payment appeals within 7 days. One plan reported 60 days, but their grievance procedures stated that decisions should be made within 30 days. This information was in the grievance procedures for four plans (although one answer differed from what was in the procedures) and absent in one.

5. Do plan members have access to the names of members of the review panel?

Two plans said this information would be released upon request, one plan stated yes, and one plan noted that review panels are not used but the name of the reviewing physician is available. One plan noted that individuals are used for initial reviews, and they correspond directly with the member. If outside reviewers are needed, their names are not routinely provided. This was in the grievance procedures of only one plan.

6. Describe the first level of a formal appeal.

For all plans, senior staff are involved in the appeals process at this stage. The process included identification of the problem, referral to the appropriate decision-makers, case review, and member notification of the decision. The decision may be made by an individual, such as the Medical Director (two plans), Claims Specialist (one plan), other physician reviewers (two plans), or a combination of the above (one plan). All five plans described a first level appeal in their grievance procedures.

7. How many days does the plan have to respond?

One plan stated 10 days, one plan stated 10 days unless the appeal is expedited, one plan stated within 1 day for expedited appeals and within 2 days for standard appeals. One plan repeated their answers from Question 5. One plan reported that their review procedures are based on ERISA guidelines, which allow 60 days; however, their grievance procedures state that they must respond within 30 days.

8. Is there a second level appeal?

All plans report that second level appeals are available.

9. Does the plan member have a right to appear before the panel?

Three plans reported that plan members can appear before panels; this information was documented in one set of grievance procedures. Two plans do not use panels.

10. Is there a third level appeal?

Three plans stated that there is no third level appeal, but one of these plans mentioned that a decision may be reconsidered if new or additional information is received. One plan allows their enrollees a third level appeal to their Appeals Committee. This was documented in their grievance procedures. One plan replied that a third level appeal was available, but they did not describe the process.

11. Does the plan have expedited appeal?

All plans have expedited appeals, but one plan did not describe the process.

12. Can the plan member complain orally?

All plans allow enrollees to complain orally. One plan requires all retrospective appeals to be made in writing, and one plan noted that oral complaints are not tracked as part of the formal appeals process.

13. Are there accommodations for non-English speakers and the handicapped?

One plan simply stated yes, while the four other plans explained they had access to interpreters for non-English speaking enrollees and TTD devices for the hearing impaired. This information did not appear in any of the grievance procedures.

14. What happens when a member calls with a complaint or concern?

Three plans reported that all calls are documented and tracked in an electronic documentation system. The complaints are addressed, investigated, and resolved. One plan stated that whomever answers the call will attempt to resolve it or refer it on to their immediate supervisor. Another plan also has the receiver of the call try to resolve the issue, and allows for the caller to submit a formal appeal if they are not satisfied. This information is outlined in the grievance procedures of all plans.

15. Is there a tracking system?

All five plans have some form of tracking system. One plan tracks complaints relative to service and is currently developing a system relative to UR. Another plan tracks UR appeals and records (but does not aggregate) claims appeals. One plan uses both an electronic and written system. Tracking systems were described in four grievance procedures.

16. Are complaints made through the Bureau of Insurance tracked separately?

Four plans track these complaints separately. One plan includes them in their regular complaint tracking.

17. Is there anything unusual about the definition of a complaint?

One plan defined a complaint as "an expression of dissatisfaction regarding an administrative issue;" any other type of problem is defined as something else, such as a grievance. One plan defined this term as "an oral and written expression of dissatisfaction or a written request for an appeal. Grievances are not considered complaints." One plan defined a complaint as "any correspondence questioning the handling of a claim or the benefits paid." In addition, this plan separates and clearly defines complaints and grievances. Two plans stated that there was nothing unusual about the definition of a complaint. Three plans have a definition of complaint in their grievance procedures.

18. If the plan subcontracts with a mental health company, who handles complaints?

One plan reported that this depends on the nature of the complaint (administrative versus medical) and the contract with the specific provider. One plan stated that it depends upon the level of appeal. One plan stated that their outside vendors handle first and second level appeals and report results to the company; they do track and handle appeals that are made to them directly. Two plans do not subcontract with any mental health company or providers.

19. What is the basis for deciding medical necessity?

One plan uses established inpatient or outpatient criteria based on national guidelines that were included with their grievance procedures. Another plan uses written medical criteria and has a formal process for deciding medical necessity, which was attached to their grievance procedures. Another plan uses Milliman and Robertson and Medical Procedure Review criteria in conjunction with internally developed criteria, but this was not documented in the grievance procedures; these criteria are subject to annual review by the medical director and a committee of physicians. Two plans replied that they use peer developed, nationally accepted clinical criteria, but did not specify what the criteria were.

20. How are Medicaid grievances handled? Medicare? Federal Employees Health Benefit Plan (FEHBP)? Are grievance procedures different for these groups?

This question was not applicable to three plans. One plan does not enroll Medicaid beneficiaries, there is no difference for Medicare enrollees in terms of grievance procedures, and second appeals for FEHBP members are handled through OPM. This information was not in their grievance procedures. The plan that did not submit grievance procedures replied that they only handle Medicaid enrollees in Maryland, they use HCFA regulations for Medicare enrollees, and use OPM rules for FEHBP members.

21. Does the grievance procedure reference Chapter 54 of Title 38.2 of the Code of Virginia? Are the procedures commensurate with Chapter 54?

One plan does not specifically reference Chapter 54, but their grievance procedures include a chart outlining the appeals process that is commensurate with Chapter 54. Another plan reported that they are commensurate with Chapter 54, but it is not referenced in their grievance procedures. Three plans reference Chapter 54 in their grievance procedures.

22. May a provider acting on behalf of an enrollee initiate a grievance?

All five plans allow this practice. This was documented in two grievance procedures.

23. What are the positions and titles of the plan review committee that decides grievances?

One plan does not use a review committee; physicians decide all grievances. One plan has the Medical Director decide first appeals and uses a regional appeals committee (including an MD) for second appeals. One plan has at least five members, including the medical director, and another plan has a committee of six, including the claims specialist and the medical director. One plan stated that the committee members vary based on the type of appeal or review.

Comments: It is not clear if members are excused from the committee if they have been involved in prior decisions relating to the case.

Conclusions: Grievance procedures from the non-HMO companies were on the whole, more straightforward than those from HMO companies. Different definitions were given for complaints and grievances, and many of the details for grievances were outlined in the actual procedures. These companies did not use the term "grievance procedures", so we analyzed the information they sent to us, which often included member handbooks.

NAME OF INDEMNITY GROUP	*QA PLAN*	*GP PLAN*
PRUDENTIAL MID-ATLANTIC	Not related	Responded to Questions but did not provide the Plan
MUTUAL OF OMAHA	1997	1991
EMPLOYERS HEALTH INSURANCE	1997	1997
TRIGON BLUE CROSS BLUE SHIELD	1997	1997
AFLAC	Responded - No related plans	Responded - No related plans
THE GUARDIAN	Did not respond	Did not respond
MASS MUTUAL	Did not respond	Did not respond
UNUM	Responded - No related plans	Responded - No related plans
TRAVERLERS	Did not respond	Did not respond
PRINCIPAL MUTUAL LIFE	Did not respond	Did not respond
COMBINED INS. CO.	Responded - No related plans	Responded - No related plans
PORTIS BENEFITS INS. CO.	Did not respond	Did not respond
NEW YORK LIFE	in the process of responding	in the process of responding
STATE FARM MUTUAL AUTO	Responded - No related plans	Responded - No related plans

APPENDIX G

CONSUMER AWARENESS SURVEY

Appendix G: Consumer Awareness Survey

Feasibility

In response to the request to assess the feasibility of surveying covered populations to determine awareness of their rights and responsibilities pertaining to complaints, grievance procedures, and protections afforded under state law, the Department of Health Evaluation Sciences reached the conclusion that an appropriate consumer survey addressing the concerns of HB 2785 could be conducted within the time frame of the study.

Several factors were considered in reaching the above conclusion -- designing and testing an instrument to ensure scientific validity and reliability, determination of a sample population, availability of an experienced research organization, and the cost of performing the study. A total of eight (five private and three public) survey research organizations were contacted.

In addition, DHES also looked at published research on health care quality and consumer satisfaction in managed care plans. According to the literature, managed care patients receive more preventive care, receive earlier treatment for illness, and achieve similar or better outcomes from serious illness than fee-for-service patients. They are also substantially more satisfied with their care and coverage than those with traditional coverage. However, a major criticism of previous surveys is the lack of questions that allow respondents to mention problems with or complaints about their managed care coverage. The instrument used in this study would need to address these issues, especially those involving patient experience with grievance procedures. In addition, many of the instruments used in published studies have not been tested for validity or reliability.

Southeastern Institute of Research, Inc., of Richmond, Virginia was selected to design, implement, and analyze a randomized survey of consumers of health insurance products in the Commonwealth of Virginia. Their report is attached to this Appendix.

Southeastern
Institute of
Research, Inc.

2325 West Broad Street
Richmond, Virginia 23220
804 358-8981

Research Report:

Virginia Consumer Health Insurance Study

September 22, 1997

Prepared For:

**UNIVERSITY OF VIRGINIA
DEPARTMENT OF HEALTH
EVALUATION SCIENCES
CHARLOTTESVILLE,
VIRGINIA**

TABLE OF CONTENTS

READING THIS REPORT

This report has been designed to meet the needs of a wide variety of individuals. While there is sufficient detail to meet the needs of those who may be implementing any changes that flow from the research, it is possible to get the key points by reading only selected portions of the report. All paragraphs in the Executive Summary and in the Detailed Findings begin with the key point of the paragraph highlighted followed by supporting detail or further clarification.

Listed below is a guideline for readers who seek varying depths of understanding of this study.

A global understanding is possible by reading just the Executive Summary. This is designed to be a standalone document for busy senior managers and those who are interested in the "big picture" findings from this study and any recommendations that may flow from it.

A general understanding is possible by reading the Executive Summary and the numbered paragraphs in the Detailed Findings, either in full or just the underlined portion that highlights the main point. This is designed to give the manager the important findings from the total sample. All key numbers are included so the tables are not necessary.

A more in-depth understanding comes from reading the bulleted points in the Detailed Findings as well as the numbered paragraphs. The bulleted points describe significant differences discovered among subgroups, such as where customers differ from non-customers. All key numbers are included so the tables are not necessary, although the source of each finding is referenced by table number should the reader want to match the report to the tables.

Additional insight may come from exploring the tables in more detail. This is particularly true should additional management questions arise than those addressed in the study.

BACKGROUND & PURPOSE

This report summarizes the findings of a telephone survey conducted among Virginia residents in August, 1997.

The University of Virginia Department of Health Evaluation Sciences undertook this study to understand consumer awareness of and experience with the complaint procedures of health care insurers, and consumer awareness of resources for resolution of grievances.

As an awareness study, the primary objective for this research centered on the extent to which healthcare consumers are aware of their health insurers' informational, complaint, and grievance procedures, to what extent they utilize them, and their experiences when using them. Other key objectives were exploring the types of health insurance consumers possess, and understanding any barriers that may exist to the utilization of the insurers' procedures.

This report was prepared by Southeastern Institute of Research, Inc. (SIR), a full-service professionally staffed marketing research firm. Since 1964, SIR has completed more than 7,000 studies for a variety of clients, including hospitals and other healthcare organizations; educational institutions and government at all levels—federal, state, and local]. SIR collaborated with The University of Virginia Department of Health Evaluation Sciences to design this research study and develop the questionnaire. All other aspects of this study—including sample generation/management, pre-testing, telephone interviewing, data processing, analysis, and reporting—were performed by SIR at its Richmond office.

METHODOLOGY & PROCEDURES

SIR completed telephone interviews with 1009 Virginia residents in August 1997. Interviewers spoke with the person who makes health insurance decisions for households with health insurance, introducing this as a study on health insurance. The client was not identified in the introduction.

The key issues measured by the questionnaire are:

1. Type of health insurance, as perceived by consumers
2. Consumer experience with simple requests for information from the household's primary health insurer
3. Consumer awareness of insurer's written complaint or grievance procedures
4. Consumer experiences with verbal complaints
5. Consumer refraint from complaining and reasons for refraining
6. Consumer experiences with written complaints or grievances
7. When and how consumers learn of insurer's formal grievance procedures
8. Assistance in the grievance process provided by the consumer's doctor or other healthcare provider
9. Consumer concerns with the grievance process
10. Length of time to resolution of a formal grievance
11. Consumer awareness of means for resolving issues when the insurer is uncooperative
12. Consumer awareness of procedures to complain against doctors and other healthcare providers
13. Perceived health of household
14. Demographics

The universe studied is Virginian health insurance consumers who are the individuals responsible for making decisions about their household health insurance. SIR identified each respondent by requesting to speak with the person most responsible for the household's healthcare decisions, including health or medical care insurance.

Sampling was accomplished by applying a random digit dialing process to a sample of all the households living within Virginia. Interviews were then conducted with only those households that qualified. Qualifications required that the that the household have health insurance, and that the respondent be the person most responsible for the household's health and medical care decisions, including health insurance decisions. The sampling was disproportionate to ensure representative samples for each region of the state, based on

county population and segmented by Virginia's six Planning Districts: Tidewater, the Valley, Central, Southside, Southwest, and Northern Virginia. The total sample of 1009 yields a maximum statistical error of ±3.1% at the 95% level of confidence.

Interviewing took place between August 11 and August 28, 1997. SIR conducted all interviews from its 43 station central telephone bank with direct supervision over all calls. This process resulted in consistently high-quality interviews as supervisors were immediately available to resolve any questions brought up during interviewing. The survey was pre-tested prior to actual fielding in an effort to eliminate confusing questions or wordings and to ensure that the survey was meeting objectives. Interviews were conducted between 5:30 p.m. and 9:30 p.m. during the week and 11:00 a.m. and 4:00 p.m. on weekends, unless a respondent requested another time for an interview. If necessary, interviewers attempted to reach each telephone number on the sample at least four times on various days.

Tabulation for this study was initiated and completed by SIR's Data Development Department. Both a telephone interviewing supervisor and a data processing clerk edited all questionnaires prior to actual coding to ensure the highest possible level of accuracy. The data were electronically keyed, 100% key-verified, and processed on SIR's own in-house tabulation equipment that permits multilevel selection criteria.

Statistical tests have been performed to determine where the apparent differences are "statistically significant," given the number of people asked the question and the percentage who gave a particular response. The significant differences are discussed in the "Detailed Findings" section and highlighted in the Executive Summary.

Tables that show all the data collected in this study are included. Responses are shown for the total sample as well as key subgroups such as respondent region, age, and income. The percentages of some questions may exceed 100% due to the rounding of numbers and/or multiple responses permitted for that particular question. The tables are referenced by number in this report.

EXECUTIVE SUMMARY

Relying on consumers' descriptions of their health insurance plans does guarantee certainty in understanding the type of insurance they possess. In today's intricate health insurance environment, plan options are complex, and the terms used to describe them may be confusing to some. Literature supports evidence uncovered in this research which indicates that as many as 20% of insured consumers are unable to describe what kind of insurance they possess. The data themselves, as well as anecdotal information revealed in the course of this study, suggest that some consumers are confused or unclear as to what sort of insurance they have. As an awareness study, it was a goal of this research was to learn what kind of insurance Virginia health insurance consumers *perceive* they have.

- Most insured Virginia households – three-quarters – say they have private health insurance obtained through a household member's employer. One in eight say they have private insurance obtained directly by the household. One in five claim Medicare, and one in thirteen claim Medicaid coverage.

- One-quarter of insured households say they bear the entire cost of their primary health insurance. In the majority of households, an employer pays or helps to pay for the household's primary insurance; in half of these, the cost is shared between the employer and the employee.

- A little more than half of insured Virginians say their household's primary health insurance plan requires them to see a specified doctor or doctors, while a little less than half report their plan permits them to see any doctor they choose. Among the whose plan requires that they see a specific doctor, one-third say they must see one doctor from whom they obtain referrals to see others, while one-quarter say they can choose a physician from the insurer's directory.

- One-third of consumers describe their household's primary health insurance as an HMO, and another one-third describe their plans as 'traditional.' Another one-quarter describe their plan as a preferred provider organization (PPO), and only a few (4%) say they belong to a point of service plan (POS). However, one in ten are unable to describe their plans according to the categories given.

- Only one-third of Virginia consumers who have health insurance make a simple informational request of their insurer and most obtain answers easily, however, one in ten encounter difficulty. It appears that most problems getting information relate to the timeliness of the response, not getting a satisfactory answer, or obtaining no response at all.

- Very few consumers make a verbal complaint to their insurer, but it appears nearly half of these have difficulty getting the complaint resolved. Only about one consumer in seven complains verbally, but almost half of those who do encounter difficulties

getting these verbal complaints resolved, including nearly one-quarter who say resolution is very difficult, although about as many say it is very easy.

- Some consumers want to complain to their insurer but do not, believing it will not do any good or they will not get satisfaction. Most consumers do not feel a need to complain, but one out of eight say they have wanted to complain at some time, yet decided against it.

- Nearly half of all insured Virginians do not know to whom they would turn if they had a written grievance and found their insurer to be uncooperative. While over half of insured consumers believe they know to whom they would turn to get a grievance with an uncooperative insurer resolved, almost as many do not know.

- Over three-quarters of those who know to whom they would turn if they had a written grievance with an uncooperative insurer say they would either turn to their employer, or they would continue to work with their insurer. Looking at it another way, among the total population of insured Virginians, one in five would seek help from an employer, and another one in five say they would continue to pursue resolution with their insurer if they had a grievance and found their insurer to be uncooperative. Only 10% would seek assistance from the state insurance commission or insurance regulators.

- One-third of all consumers are not aware of their insurer's grievance process. Most who are aware say they learn about the procedure from reading the insurer's brochures or at employee meetings. However, it appears that many learn of the process through informal means such as word of mouth.

- Very few health insurance consumers - only 4% of all insured Virginia households - file formal, written complaints against an insurer, but many do not receive procedures and find the grievance process hard to understand. It appears that about one-third do not recall receiving a written description of the grievance procedures at any time. About one-third of all the consumers who do file written grievances say they find the grievance process hard to understand.

- It appears a majority of consumers who file grievances receive help from their doctor or another healthcare provider, and most believe this assistance to be helpful. Two-thirds of those filing receive assistance from their doctor or another healthcare provider, either of whom provide information to the insurer at the time of the grievance. Two-thirds say this assistance is "very helpful".

- Consumers' greatest concerns regarding the grievance process appear to relate to getting resolution or getting the bill paid. About one-third mention these concerns. Additionally, a few mention other concerns, such as delayed response, lengthy process, lack of follow-up or feedback, uninformative insurer employees, and difficulty following the procedures or rules.

- Two-thirds of Virginia consumers are not aware of any procedure to file a complaint against a doctor, pharmacist, or other healthcare provider; most who are learn about it from their insurer's brochure or employee meetings.

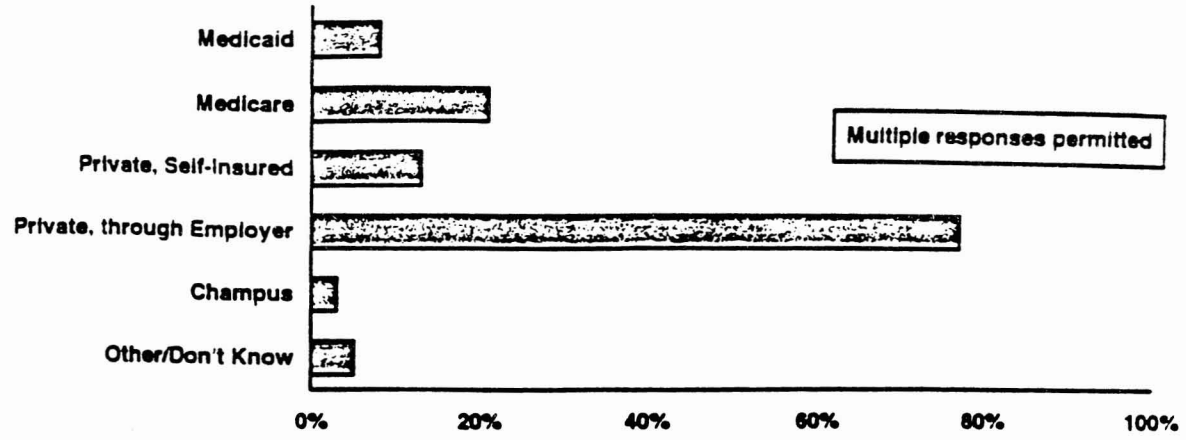
DETAILED FINDINGS

Perception of Insurance Coverage

It should be noted that relying solely on consumers' descriptions of their health insurance plans does not provide certainty in understanding what kind of insurance they actually possess. In today's intricate health insurance environment, plan options are complex, and the terms used to describe them may be confusing to some. Literature supports evidence uncovered in this research which indicates that as many as 20% of insured consumers are unable to describe what kind of insurance they possess. The data themselves, as well as anecdotal information revealed in the course of this study, suggest that some consumers are confused or unclear as to what sort of insurance they have. As an awareness study, the goal of this research was to learn what kind of insurance Virginia healthcare insurance consumers *perceive* they have. Consequently, to minimize error and clarify the analysis, when constructing the crosstabulations upon which the analysis rests (the Tables found in the Appendix), a filter was applied to the "Kind of Coverage" category (or "banner"). All households that reported more than one kind of insurance coverage were filtered out, so that the only responses represented are from consumer households with just one kind of insurance: Medicare, Medicaid, private insurance obtained through an employer, private insurance obtained directly by the household, or some other kind. The data found under this banner will represent only households where just one type of insurance is present in the household, thus we can be more confident that when a consumer responds to a question about grievances, for instance, that the response given pertains to the one particular kind of insurance that household has. This filter does *not* apply to the first set of findings below - those pertaining to descriptions of insurance type, but only to the data in subsequent sections relating to the insured household's *primary* health insurance, which comprise the bulk of the study. Discretion should be used, however, when interpreting all data that are related to the type of insurance the consumer has, due to the high degree of uncertainty inherent in data of this type.

1. Most insured Virginia households say they have private health insurance obtained through a household member's employer (77%). Private insurance that is obtained directly by the insured household is found in 13%. One in five households (20%) have Medicare coverage; another 8% have Medicaid coverage, and 3% are covered by CHAMPUS (provided to members of the military). A few (5%) either claim a different kind of insurance, such as insurance provided through a college, association, or union, or are unable to describe their coverage according to the options provided. Filtering was not applied to these data; multiple responses were permitted, as households may have more than one type of insurance. - *Table 1*

Household Insurance Types

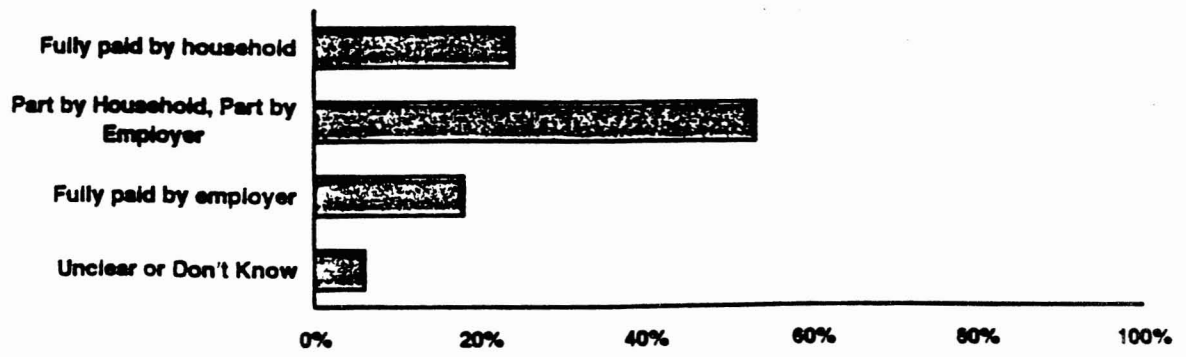


- As expected, insured households where the insurance decision-maker is a senior are much likelier to have Medicare coverage (91% of those 65 and over, compared to 12% for those 45 to 64, and 4% to 5% age 45 and under).

- Insured households where the insurance decision-maker is aged 65 or above are also likelier to be covered by private, self-obtained insurance (27%, compared to 9% to 13% of those under 65).

2. One-quarter of insured households bear the entire cost of their primary health insurance (24%). In most cases (71%), an employer pays or helps to pay for the household's primary insurance; including half (53%) where the cost is shared between the employer and the employee, and 18% where insurance costs are fully paid by an employer. A relatively large number, 6%, are unable to describe how their household's primary insurance is paid, or describe it as Medicare, Medicaid, or "government"-paid. – *Table 3*

Payment for Household's Primary Insurance

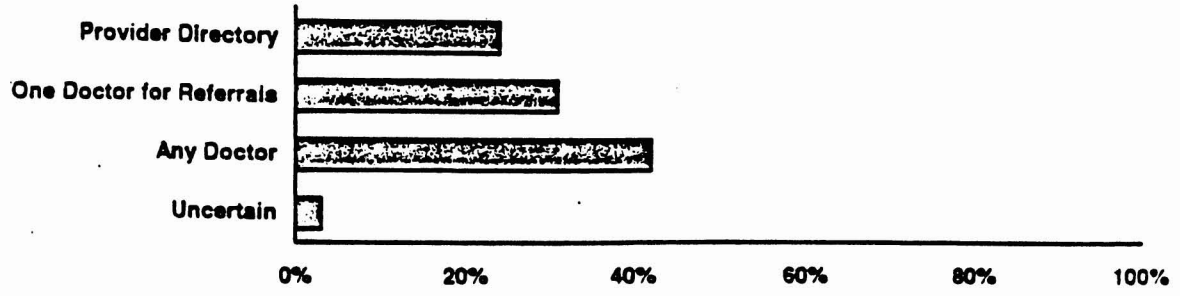


- The proportion of fully self-paid insured households rises in Southwestern Virginia, and falls in Northern and Central Virginia. Over one-third of

Southwestern Virginia households are fully self-paid (36%), compared to the Central and Northern parts of the state, where only 18% – 19% carry full financial responsibility for their insurance.

3. About half of insured consumers say their household's primary insurer requires them to see a specified doctor or doctors (55%), while 42% report their plan permits them to see any doctor they choose. Among the 55% whose plan requires that they see a specific doctor, 31% say they must see one doctor from whom they obtain referrals to see others, while 24% say they can choose a physician from the insurer's directory. A few are unable to say what their plan's option is regarding physician choice (3%). – *Table 5*

Physician Options Under Household's Primary Insurance Plan

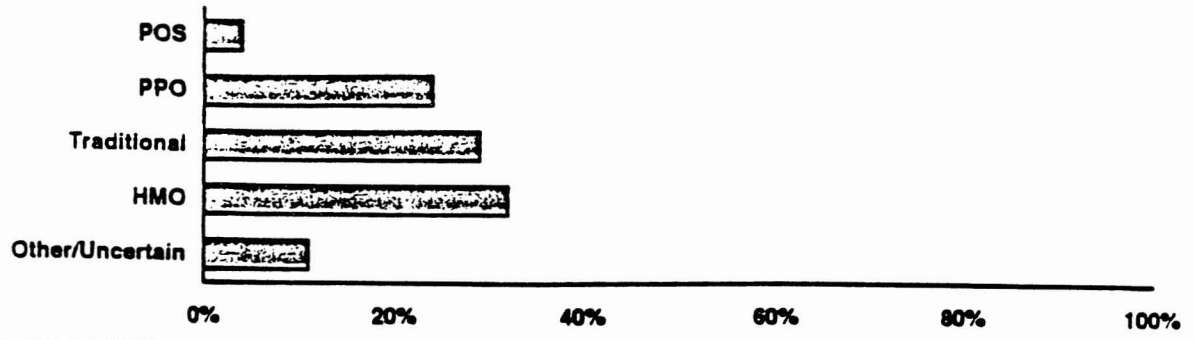


- Households in the Southwest appear more likely to be covered by a traditional plan than the other regions of the state (60%, versus 37% to 46% in other regions). Likewise, only 35% of Southwest households are covered by managed care plans, compared to 51% to 61% in the rest of the state.

- Households with older insurance decision-makers appear likelier to be covered by traditional plans than are those with younger decision-makers. Three-quarters of households with decision-makers aged 65 or older have traditional insurance (77%), compared to 41% of those 45 to 64, and 31% to 32% of those 44 or younger. In households where the decision-maker is aged 65 or older, 18% are covered by managed care plans; this drops to 55% of those aged 45 to 64, and 66%-67% of those aged 44 or less.

4. One-third of consumers describe their plans as health maintenance organizations, and another one-third describe their plans as 'traditional' (33% HMO and 29% 'traditional'; the difference is not statistically significant). Another 24% describe their plan as a preferred provider organization (PPO), and 4% say they belong to a point of service plan (POS). One in ten, are unable to describe their plans according to the categories given (11%). - *Table 6*

Household's Primary Insurance Plan



Informational Request Experience

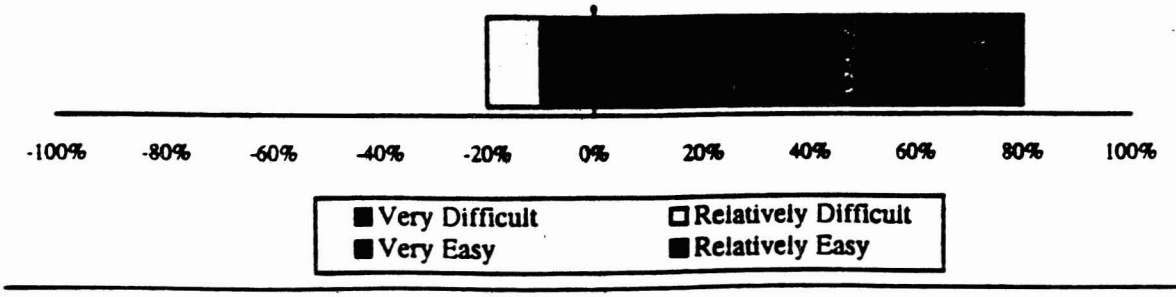
1. Two-thirds of all consumers never make even a simple request of their health insurer (68%); only one-third report ever making any request (31%), and 1% do not know. - *Table 7, 7a*

   - Older consumers are less likely to make informational requests of an insurer. with only 20% of those in the 65 and over group making requests, compared to 29%-30% of those 64 or under.

   - Medicare and Medicaid consumers appear to be less likely to make informational requests; only 7% of Medicaid consumers and 15% of Medicare consumers in this study report making such requests, however, caution should be used when viewing these numbers, due to small sample sizes.

2. Of those who do make requests, twenty percent have a difficult time getting answers. including equal numbers who say answers are "relatively difficult" and "very difficult" to obtain (10%–11%). Most report ease obtaining answers (79%), including nearly half who say it is "very easy" (45%). A few (1%) cannot say. –*Table 8*

Ease of Getting Answer to a Simple Request for Information

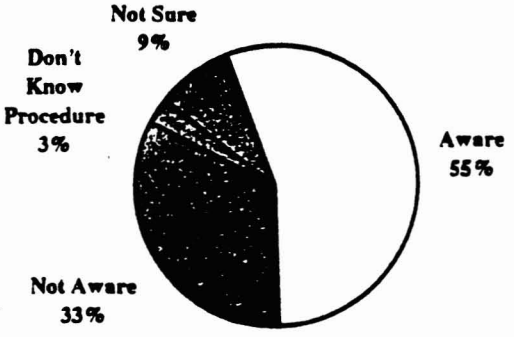


3. It appears that most consumers who have difficulty getting answers to simple requests for information encounter problems related to the timeliness of the response, reaching the right person, or did not get a satisfactory answer (22% say timeliness, 16% say satisfaction, 13% never obtain a response, and 11% say they had to go through too many people or were transferred a lot – the difference among these is not statistically significant). Smaller numbers of consumers mention other problems, such as inability to find someone who could answer the question, having to make multiple requests, or having to speak to a supervisor, or receiving wrong or confusing information. Caution should be used when viewing these numbers, due to small sample sizes. - *Table 9*

Formal Complaint or Written Grievance Procedure Awareness

1. One-third of all consumers are not aware whether their insurer has a formal procedure for complaining or filing a grievance (33%). Over half say they are aware (55%), but another 9% are not sure, and 3% are aware but don't know the procedure. - *Table 10*

Grievance Procedure Awareness



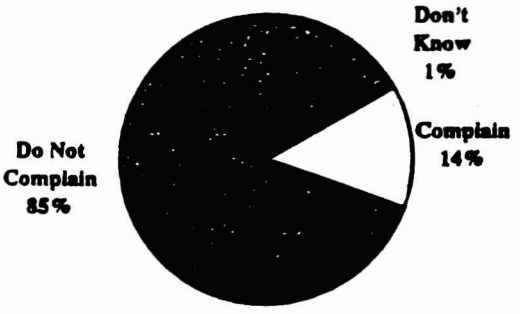
2. Most of those who are aware learn about the procedure from reading the insurer's brochures (69%), and 20% learn at employee meetings. The remainder learn of the procedure through other means, such as human resources personnel at work, word of mouth, from a coworker, through professional exposure, from someone at their doctor's office. - *Table 11*

   - As age rises, so does the likelihood that the consumer learns about the grievance process from reading about it in the insurer's brochure. Among consumer households where the insurance decision-maker is under 35, 59% report they learn it from a brochure, but this rises to 74% of those in the 45-64 age group, and 76% in the 65 and above group.

Verbal Complaint Experience

1. Few people make verbal complaints to their insurer (14%), 86% do not complain verbally, and 1% cannot say. - *Table 12*

Consumers Who Make A Verbal Complaint

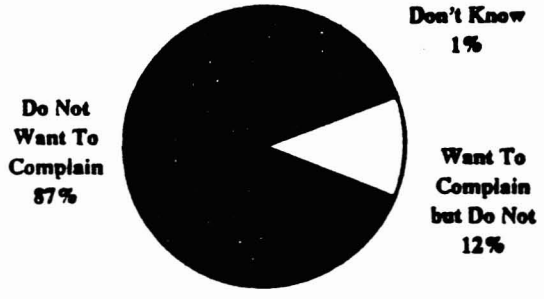


2. It appears that about half of the insured Virginians who make verbal complaints encounter difficulty getting them resolved (43% say they had difficulty getting resolution; 53% say it is easy – the difference is not statistically significant). One-quarter say the resolution is "very difficult" (23%), and an equal number (28%) say resolving these complaints is "very easy"; 4% say they are unsure.– *Table 13*

Consumers Who Refrain From Complaining

1. One out of eight Virginia health insurance consumers want to call or visit their insurer to complain about something, but decide not to. When asked whether they have ever wanted to complain to their insurer about something, but then decided not to complain for some reason, 12% say "yes". Most consumers, 87%, say they do not, and 1% are unsure. - *Table 14*

Want To Complain But Do Not



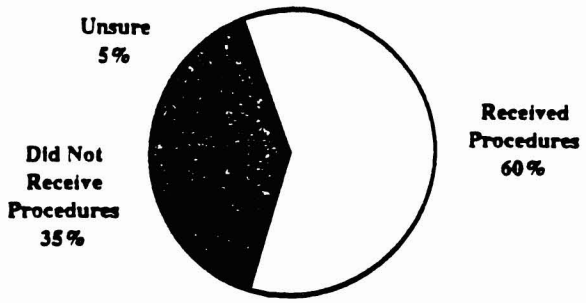
2. Most of those who want to complain but do not decide not to because they anticipate it would not do any good, or they would not get satisfactory results, or they think that making a complaint would be too much trouble (35% say they would not get satisfaction, 29% say it would be too much trouble). The rest give a variety of reasons, such as not having time, believing the issue would resolve itself or did resolve itself, feeling they themselves were at fault, or did not read the insurer's rules, thinking it was not worth the legal cost, difficulty making an appointment, not knowing whom to contact, "poor attitudes", or fear of coverage being dropped. - *Table 15*

Written Grievance Experience

1. Very few insured Virginia households file a written complaint or grievance against their primary insurer (4%); the great majority (96%) have never done so. - *Table 16*

2. One-third of the Virginia consumers who file written grievances with their insurers report they are never given descriptions of the insurer's grievance procedures in writing at any time (35%); another 5% cannot say whether they received written procedures or not. Among those who file, 60% report receiving written copies of grievance procedures at some time. - *Table 17*

Filed a Written Grievance and Received Written Procedures



3. Three-fourths of the Virginia health insurance consumers who make written grievances to their insurers and receive written descriptions of the insurers' grievance procedures, receive those descriptions at the time they enroll in the plan (75%). The remainder, however, are either not given the procedures when they enroll, or cannot say when they are received (25%, of whom 17% do not receive procedures at the time of enrollment, and 8% who do not recall when they receive them; the difference is not statistically significant). - *Table 18*

4. It appears that about half of Virginia health insurance consumers who file formal grievances are not given written descriptions of the insurers' grievance procedures at the time they file (54%; 38% of the respondents in this study report being given procedures when they filed – the difference is not statistically significant). A small number, 8%, cannot say when the procedures were provided. Caution should be used when interpreting this information, as the number of individuals interviewed in this study who have filed grievances is too small to reliably reflect all Virginia consumers who file grievances. - *Tables 19, 20*

5. It appears that some of the consumers who file written grievances receive a description of the insurer's procedures over the telephone (45% say they do; 48% say they do not – the difference is not statistically significant). - *Table 21*

6. One-third of the Virginia health insurance consumers who file formal written grievances find the insurer's procedures difficult to understand (33% including 5% who report that the procedures are "very difficult". Most believe the procedures are easy to understand (60%), including 18% saying they are "very easy". A few, 8%, cannot say. - *Table 22*

7. It appears that a doctor or another healthcare provider assists many consumers by providing information to the insurer at the time of the grievance (63%reprt receiving assistance, 38% say they received no such assistance – the difference is not statistically significant). - *Table 23*

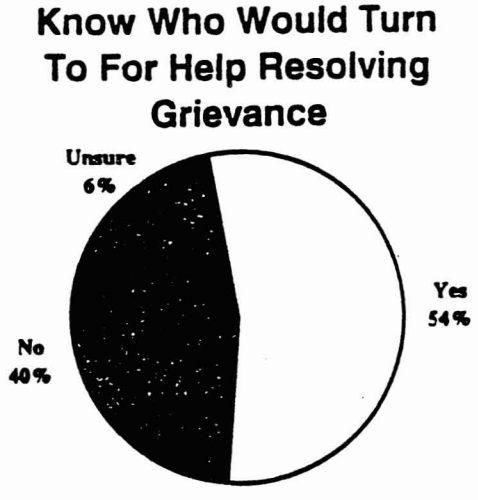
8. Most consumers who are assisted by their doctor or other healthcare provider in providing information to the insurer at the time they file a grievance report that the assistance was helpful (87%), including 67% who say it was "very helpful". A few (7%) report that the assistance was not helpful at all, and a few (7%) cannot say. - *Table 24*

9. Consumers' greatest concerns regarding the grievance process relate to getting resolution or getting the bill paid; 33% indicate this. Additionally, consumers mention other concerns, such as difficulty or delay in getting a response, the length of the process, a lack of follow-up or feedback, uninformative insurer employees, difficulty following the procedures or rules. A few consumers have no concerns with the process, or voice complaints with the insurer's policies themselves. -*Table 25*

10. It appears that many consumers who file written grievances do not receive a final outcome within 30 days of filing: 40% did not get a resolution until more than 30 days after filing; 33% got an outcome within 30 days (the difference between 40% and 33% is not statistically significant). Only one in ten several respondents to this study received an outcome within a week after filing (10%), and 18% are still awaiting a final outcome. - *Table 26*

Awareness of Resources for Resolution

1. Nearly half of all insured Virginians do not know or are unsure to whom they would turn to get the matter resolved if they had a written grievance and found their insurer uncooperative (46%, including 6% who are unsure). About half report that they do know to whom they would turn for assistance (54%). - *Table 27*



2. The majority of these consumers, who say they know to whom they would turn for resolving a grievance in a case where the insurer is uncooperative, report they would turn to their employer or to their insurer (42% say employer, 37% say insurer - the

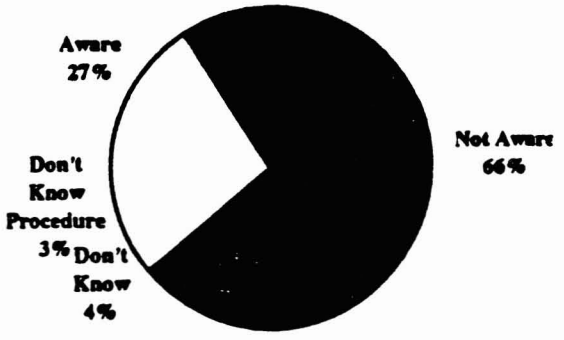
difference is not statistically significant). The 37% who would work through their insurer includes 32% who would work through their insurer's customer service representatives or its written policy, and 5% who would take the matter to their insurer's administrators. Looking at it another way, of all insured Virginians, 22% would go to their employers and 20% would still return to their insurers (the difference between is statistically insignificant), if they filed a grievance and found their insurer uncooperative. Among those who say they know whom to turn to, only 16% say they would seek assistance from various government agencies, including 10% who name the state insurance commission or insurance regulators. This is equivalent to 9% of all insured Virginians. Six percent (6%) say they would go to a lawyer, and the remainder (1%-3% each) name a variety of resources, such as their congressman, the Better Business Bureau, a friend, their physician, union leaders, the American Medical Association, etc. A few do not know or refuse to say (2%). - *Table 28*

3. Nearly half the consumers who say they know to whom they would turn to get an issue with an uncooperative insurer resolved, say they learned about it by reading about it in their insurer's brochure (46%), and another 4% learn through another insurer or insurer's representative. One in five (22%) say they learn at an employee meeting. Some, 12%, say they know through "common sense", experience, or feel it is a logical choice. The remainder give a range of answers: 5% to 7% say they learn from coworkers, family, or word of mouth; 1% to 2% name the media, their doctor's office, etc. A few, 5%, are unsure how they learn of it. - *Table 29*

Awareness of Grievance Options Against Healthcare Providers

1. Two-thirds of all consumers are not aware of any process or procedure available to file a complaint or grievance against their doctor, pharmacist or other healthcare provider (66%). One-quarter are aware of such a procedure (27%). A few say they are aware a procedure exists but cannot say what it is (3%), and 4% are unsure. - *Table 30*

Aware of Grievance Procedures Against Healthcare Providers

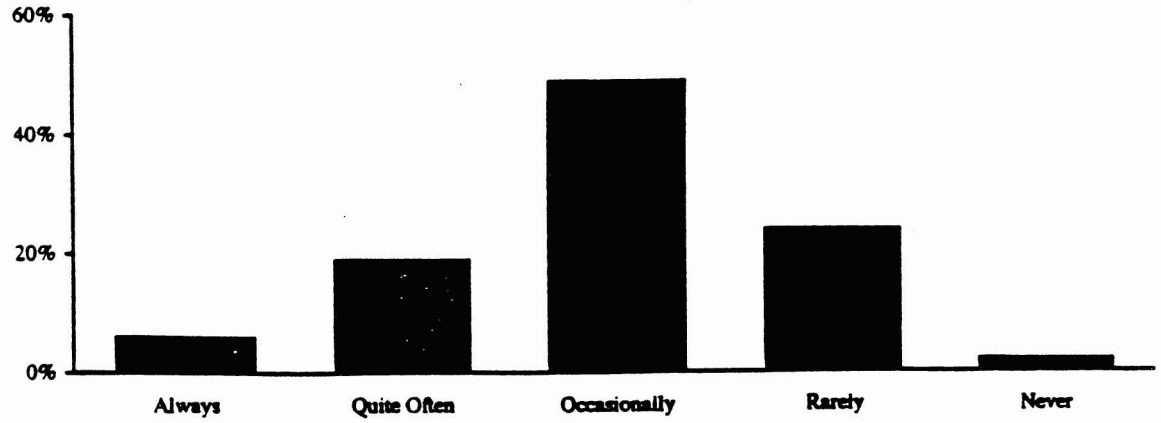


2. Nearly half the consumers who claim to be aware of a grievance process against a healthcare provider say they learn of this option by reading about it in the insurer's brochure (47%), and 4% learn through another insurer or an insurer's representative. Others say they learn at an employee meeting (16%). A statistically similar number, 12%, learn through their job, an employer, or a coworker. The remainder give a range of other answers: 5% to 7% learn from friends, family, and word of mouth, say it is "common sense", experience, or a logical choice, and a few name the media, their doctor's office, etc. (1% to 6% each). A few, 4%, are unsure how they learn of the option. - *Table 31*

Perceived Health of Household

1. The great majority of these consumers believe their households do not seek medical services often (75%). Of these, half report that someone in their household seeks medical treatment "occasionally" (49%), one-quarter say a household member seeks treatment only "rarely" (24%), and 2% say no one "ever" seeks treatment. One-quarter (25%) utilize services either "quite often" (19%) or "always" (6%). - *Table 32*

Household Members Seek Medical Services



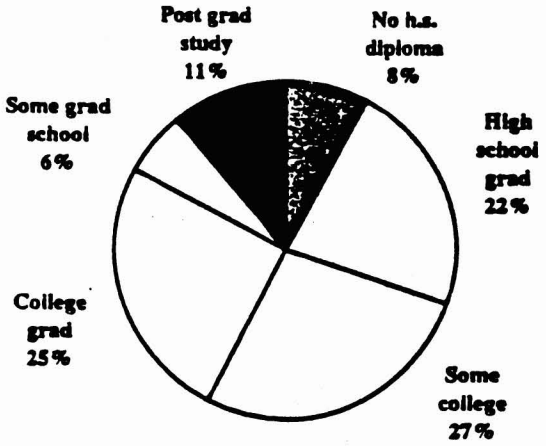
- Households with older decision-makers are less likely to say their households seek treatment only occasionally, rarely, or never. While among consumers age 65 or above, 46% say this, the number rises to 73%-78% among consumers under age 65.

2. Over half of consumers report that some member of their household seeks medical treatment only 3 times a year or even less frequently (57%), including 9% who have members seeking treatment less than once a year, and 14% who only seek treatment once a year. About one-quarter (27%) have a member seeking treatment between 4 and 11 times a year, including most (21%), who seek treatment between 4 and 7 times a year. Additionally, 15% have a household member seeking treatment once a month or more; 1% are unsure. - *Table 33*

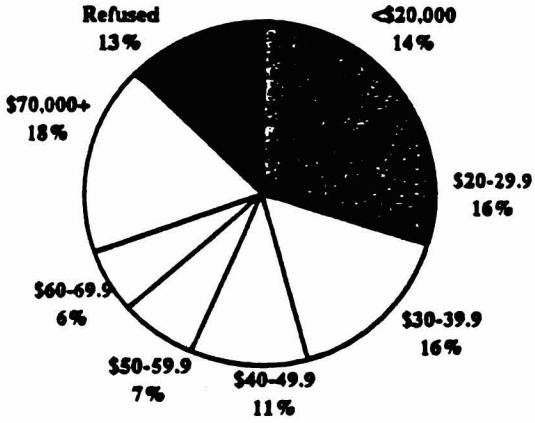
RESPONDENT PROFILE

The following graphs show the demographic characteristics of the respondents to this study.
- *Tables 35, 36, 37, 38, 39, 40, 41, 43, 44*

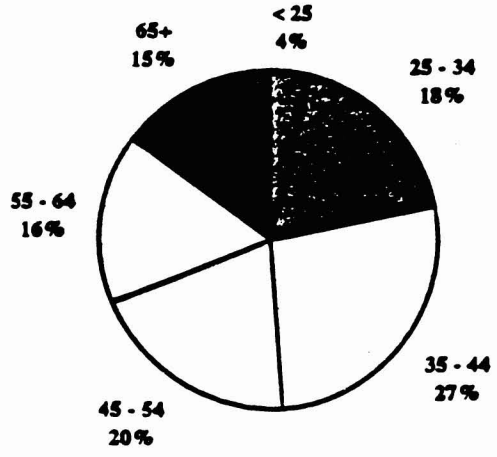
Education Level



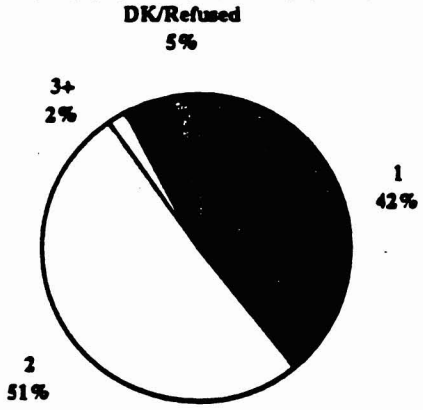
Household Income ($000s)



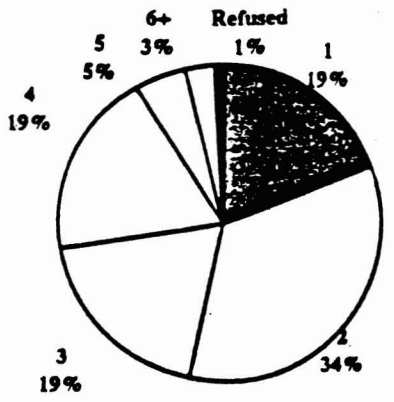
Age of Respondent



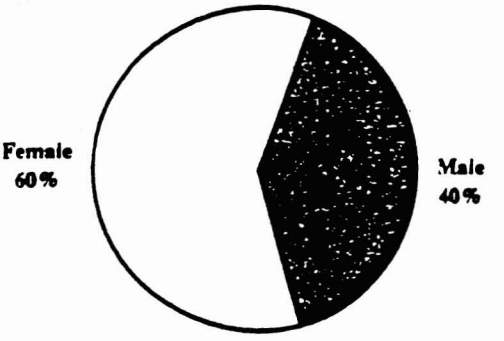
Contributors to Household Income



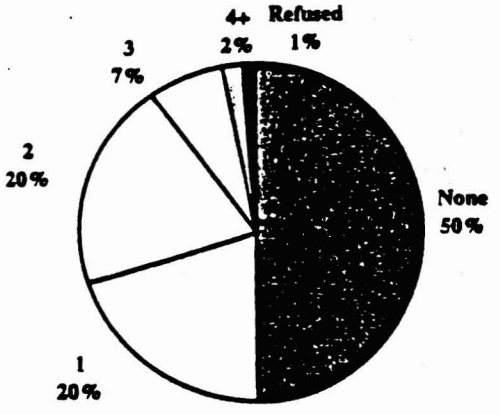
Household Size



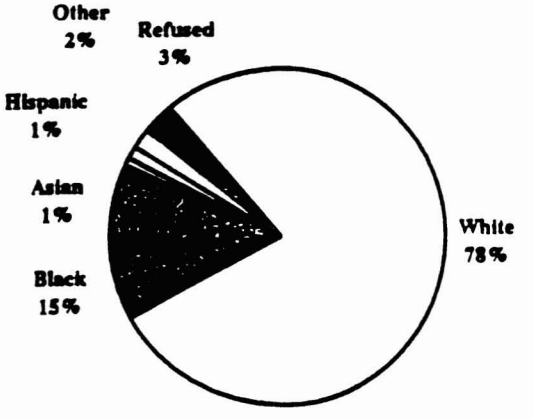
Gender of Healthcare Insurance Decision-Maker



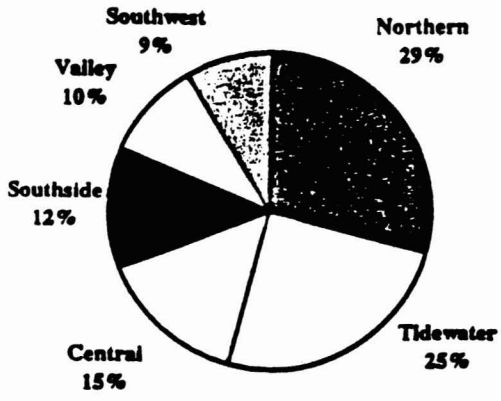
of Children



Race/Ethnic Origin



Region



Note: Regions are represented according to proportion of Virginia residents, and are based on State Planning Districts.

APPENDIX H

A REVIEW AND ANALYSIS OF THE FEDERAL AND STATE LAWS AND REGULATIONS APPLICABLE TO CONSUMER GRIEVANCE OVERSIGHT OF HMOs AND OTHER MANAGED CARE ORGANIZATIONS

APPENDIX H

A Review and Analysis of the Federal and State Laws and Regulations Applicable to Consumer Grievance Oversight of HMOs and Other Managed Care Organizations

Prepared by the Virginia Department of Health
August 20, 1997

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This paper provides a review and analysis of federal and state statutes and regulations governing grievance protections for consumers in managed care plans. While it focuses on health maintenance organizations, attention is given also to other forms of managed care such as preferred provider organizations.

This review and analysis was undertaken in response to the directive of House Bill 2785 passed by the 1997 Virginia General Assembly to study the quality of care mechanisms in place for HMOs and, in particular, to assess the sufficiency of these mechanisms to provide health care consumers with a means of having their inquiries and complaints addressed. The focus of the analysis is devoted to public oversight and statutory and regulatory authority; examination of HMO internal quality and grievance protections is a separate chapter of the HB 2785 study .

Among the most significant observations of this paper are the following:

- ERISA plans, those health plans that are self-funded by employers, are exempt from state oversight and regulation. Thus, state statutes and regulations addressing managed care protections will have no effect on individuals in ERISA plans. The number of people so affected is considerable; the Joint Commission on Health Care has estimated that one third of privately insured individuals are covered by ERISA plans. The U.S. Department of Labor (DOL) has oversight authority for ERISA plans. DOL does not have authority to intervene in beneficiary grievances or to resolve disputes, but may provide individual assistance in the form of advising beneficiaries of their rights under ERISA, and providing general information regarding how federal law may apply to a beneficiary's situation. While ERISA preempts many state laws, DOL has attempted to assist states' consumer protection efforts. A recent collaboration between the Department of Labor and Oklahoma's Department of Insurance to permit the state to monitor complaints about self-funded plans may provide a useful model for other states.

- The HB 2785 Consumer and Provider Focused Roundtables, as well as managed care complaints received by the Virginia State Corporation Commission's Bureau of Insurance and the Virginia Department of Health, indicate that many consumers and providers are confused about how to appropriately grieve an action of an HMO. Repeated reference is made to the need for assistance in "navigating the system." These agencies also receive requests for information and education. Consumers may need assistance and education in order to effectively bring their concerns to their HMOs. This study suggests that an appropriate role for VDH may be that of an educator and facilitator, similar to the Department of Labor's role with ERISA consumers.

- HMO grievance protections are found in statute in two chapters of Title 38.2 of the *Code of Virginia*: Chapter 43 contains requirements for HMO grievance systems, and Chapter 54 contains requirements for a particular type of grievance protection, grievances concerning an insurance company's utilization review or medical necessity decisions. The latter type of grievance is perhaps the most important consideration for providers and consumers. There are also state and federal statutes that establish grievance protections for Medicaid HMO enrollees. In the *Virginia Administrative Code*, Section 12 VAC 30-120-420 establishes grievance protections for Medicaid clients enrolled in HMOs. Additionally, the *Code of Federal Regulations* at 42 CFR 434.32, establishes grievance protections for Medicaid clients enrolled in HMOs. The analysis in this paper points out inconsistencies in the requirements for grievance protections under Chapter 43 and Chapter 54. It also identifies a potential need for clarification in the language of Chapter 54. Most importantly, the paper suggests a possible role for the Department of Health with regard to the regulatory oversight of Chapter 54 appeals. The Bureau of Insurance lacks regulatory authority for this oversight function, as well as the medical expertise to perform this function.

- Consumer complaints about their HMOs may reach a variety of state agencies. State employees' complaints are handled by the Department of Personnel and Training; the Department of Medical Assistance Services handles complaints from Medicaid clients; the Bureau of Insurance manages consumer complaints about all insurance plans; and the Department of Health, through an interim Memorandum of Agreement with the Bureau of Insurance, handles complaints about the quality or accessibility of care. Additionally, the Department of Health Professions handles complaints about practitioners. There is currently no mechanism among these agencies for sharing complaint data so there is no organized quality improvement effort aimed at analysis and monitoring of complaint data. This paper offers options for the State Health Commissioner to consider, which include a uniform complaint

classification system and a complaint data sharing mechanism. (Any data sharing efforts will be subject to client confidentiality limitations).

- Although the Bureau of Insurance and, more recently, the Department of Health, have the authority to investigate complaints on behalf of consumers, neither has the ultimate adjudicatory authority to mandate a remedy for the individual. Individuals would seek such remedies in court, but under Virginia law, a claimant cannot seek punitive damages. The Department of Medical Assistance Services (DMAS), however, does have this authority in that any grievance decision issued by a Medicaid HMO may be appealed by the client to DMAS in accordance with DMAS' Client Appeals regulation at 12 VAC 30-110-10. The DMAS decision in these matters is final and is not subject to any appeals.

- The grievance protections found in Chapter 43 of Title 38.2 of the *Code of Virginia* do not apply to forms of managed care other than HMOs, or to indemnity plans. Although Chapter 54 includes all forms of health insurance, it addresses one type of grievance only: denial of coverage for care. The statutes and regulations do not otherwise mandate a grievance system for any type of health insurance other than a health maintenance organization for grievances other than denial of coverage. Public attention could focus on other forms of managed care. It should be noted that DMAS' Client Appeals regulations (12 VAC 30-110-10 et seq.) are afforded to all Medicaid clients, regardless of whether they are enrolled in a Medicaid HMO, in Medallion I (a non-HMO managed care program), or in fee-for-service.

II. INTRODUCTION

Growing enrollment in HMOs and other managed care organizations has evoked increasing concern that financial incentives inherent in managed care may adversely impact access to quality health care. Recently, independent review of unresolved enrollee and provider grievances against managed care entities has emerged as a pressing consumer protection issue. This issue has been raised in House Joint Resolution 67, subsequent discussion by the Joint Commission on Health Care (JCHC, 1996), by participants in the Virginia Department of Health (VDH) August 1996 Roundtable, in legislation recently enacted by the General Assembly (HB 2785), and by other states across the nation. In addition, anecdotal evidence from consumer advocates and providers suggests that HMO internal grievance systems may be confusing, and that self-interest may preclude an objective review of consumer grievances.

An ombudsman program and an external appeals process have been proposed in HB 2785 as options for addressing independent review of enrollee grievances. An ombudsman may be defined as one who investigates complaints made by consumers, reports findings, and attempts to achieve equitable solutions (Webster's Ninth New Collegiate Dictionary, 1985). An ombudsman is foremost a fair and impartial investigator, but may maintain other roles, such as educating consumers and advocating on their behalf (see box). Various sources, both anecdotal and empirical, regarding managed care consumer disputes suggest that, for a considerable proportion of enrollees, complaint resolution involves education about their plans, assistance with navigating the internal grievance system, or advocacy with their plan on their behalf. The second option proposed in HB 2785, an external appeal process, may provide for grievance investigation, review of findings, resolution by a public or private entity and/or adjudication. Such reviews may be binding or non-binding on a managed care organization. Some consumer advocates favor an external appeal process that provides adjudicatory authority to a public entity. Under such authority, a hearing is conducted to consider all evidence, and an enforceable decision is made. Another variation of external review may involve a non-binding determination made by a public or private entity. Alternatively, a private entity could investigate a dispute and make a recommendation to the public entity with oversight authority, and the public entity would

Ombudsman Models

By definition, an ombudsman is a fair and impartial investigator. However, an ombudsman can maintain other roles as well. For purposes of this study, the following basic roles will be used as a reference for the ensuing discussion.

1) Educator/Facilitator: The ombudsman's role is to help consumers to understand their rights and responsibilities under their plans.

2) Mediator: The ombudsman attempts to resolve individual grievances by functioning as a fair and impartial intermediary between the enrollee and his or her plan.

3) Advocate: When it is determined that the consumer has cause, the ombudsman attempts to resolve the individual grievance in favor of the enrollee by communicating with the managed care plan on the enrollee's behalf.

issue a binding or non-binding decision. An external appeal process would, of necessity, limit cases to written grievances that have exhausted the HMO internal appeals process, and so are likely to address a much smaller proportion of total complaint volume. Though compatible with each other, the ombudsman program and external appeal process may differ in the types of consumer disputes they most effectively address. For example, an external appeal process may be appropriate for an enrollee whose written grievance has been through the HMO's internal grievance system, but who thinks the unfavorable decision may have been made inappropriately. In the same situation, an ombudsman could become involved in the role of advocate for the enrollee, by facilitating reconsideration or persuading the HMO to reverse the adverse decision. Or, the ombudsman could serve as impartial mediator. However, it might be inappropriate for a private or public entity to independently review and rule on a consumer complaint that had never been submitted to the HMO for consideration. For such a complaint, the Educator/Facilitator Model would be more effective, with the ombudsman providing assistance to the enrollee on how to access the HMO's internal grievance system.

External Appeal Process

An external appeal process may provide for grievance investigation, review of findings, adjudication, and resolution by a public or private entity.

HB 2785, which was signed into law by the Governor on March 21, 1997, directs the State Health Commissioner to consider whether special consumer protections are needed beyond those that exist in current law. In particular, the new law instructs the State Health Commissioner: 1) to consider the appropriate types and sources of complaints admissible within a managed care grievance oversight system (excluding "purely contractual" complaints); 2) to assess the state's oversight of alleged violations of applicable laws or regulations, including enforcement when appropriate; 3) and to evaluate whether a mechanism to adjudicate issues alleging violation of applicable laws or regulation should be established. These assessments are related to an additional request: 4) to "evaluate whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans," and depending on the judgment of that examination, "whether the Department of Health or another entity should administer the process." (§38.2-4319(C)(2)(iv) of the *Code of Virginia*)

This paper will examine some of these four directives, and set the groundwork to address the other directives later. The general method presented involves a review of the existing systems for overseeing consumer protections for managed care, including, but not limited to, HMOs. The HB 2785 Study Group determined that it is axiomatic that any new processes to be established should treat all managed care plans—if not all health plans—fairly. Finally, to the extent possible, this study will analyze existing complaint data when available, evaluate their adequacy for making valid judgments, and include suggestions for improved data collection.

III. OVERSIGHT FOR GRIEVANCE PROCEDURES

The general public and state officials have become more aware of existing grievance-type protections for the consumer of managed care products, particularly HMOs. This increasing awareness has come about slowly, and may be due in part to the variability in grievance systems and their regulation across health plans. The manner in which grievances are handled depends on two factors—the type of health plan, and the type of organization underwriting the plan. Plan types include traditional indemnity insurance (fee for service), HMOs, PPOs, and other managed care products. Entities underwriting plans may include Medicare, Medicaid, commercial insurers, and self-insured employers. These in turn determine the grievance process through the regulatory authorities having jurisdiction over the various plans. Table 1 summarizes these health plans and the regulatory authorities that oversee them; a more detailed discussion of each follows. In addition, a description of the role of the Office of the Attorney General (OAG) in grievance action is included. While the OAG's office has no direct oversight responsibilities relating to individuals with complaints, it does handle major cases affecting numerous consumers.

Table 1: Health Plan Oversight by Type		
Health Plan Type	**Entity with Oversight Authority for Grievances/ Complaints**	**Detailed Grievance/ Complaint Procedures Specified?**
ERISA self-insured plans	U.S. Dept. of Labor (DOL)	Reporting and disclosure, claims procedures
	Federal Courts	Court decisions
ERISA fully-insured plans	See "Commercial Insurance" below	
Commercial Insurance:		
HMOs	Bureau of Insurance (BOI)	*Code of Virginia*
	Dept. of Health (VDH)	*Code of Virginia* (quality complaints against providers)
	Dept. of Health Professions (DHP)	*Code of Virginia* (complaints against practitioners)
All health insurance carriers	BOI	*Code of Virginia*
	DHP	*Code of Virginia* (complaints against practitioners)
Medicaid:		
HMO (Options II and Medallion II)	Health Care Financing Administration (HCFA)	
	Dept. of Medical Assistance Services (DMAS)	Formal appeals process; toll-free recipient assistance line
	BOI, VDH and DHP	As with commercial insurance
All other, including Medallion I (gatekeeper)	HCFA	
	DMAS	Toll-free recipient assistance line
	DHP	Complaints against providers
Medicare:		
HMOs	HCFA	Oversight authority granted to PROs
	BOI, VDH and DHP	As with commercial insurance
All other	HCFA	Oversight authority granted to PROs
	BOI and DHP	As with commercial insurance
State Employees' Benefit Program:		
Self-insured plans	Dept. of Personnel and Training (DPT)	Executive appeal
HMOs	DPT	Executive appeal
	BOI and VDH	As with commercial insurance

U.S. Department of Labor and Federal Courts: Oversight of ERISA Plans

The Employee Retirement Income Security Act (ERISA) of 1974, while primarily focused on requirements for employer-based pension plans, also established requirements for employee benefit plans, including health plans. ERISA governs all self-funded private sector health plans; however, federal, state and local government employee plans, as well as church-sponsored plans, are exempt from ERISA. In 1995, approximately 32.5 million nationally were covered under these plans. In Virginia, approximately 35% of the population is covered by an ERISA plan.

The original Act contains the preemption clause through which ERISA supersedes state laws that relate to employee benefit plans. It was intended to allow employers operating in multiple states to offer standard health benefit plans to their employees without having to comply with regulations of the various states in which they conduct business. Because of ambiguities in wording of the initial Act, the federal court system has played a pivotal role in defining the scope of ERISA preemption (U.S. GAO, 1995). As a result, states may regulate insurance carriers and their policies but not employers' plans. Therefore, ERISA plans that are insured by commercial carriers are subject to state regulation and mandated benefits. Self-insured plans are exempt from state insurance laws; oversight authority for these plans rests with the U.S. Department of Labor (DOL).

As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- requiring all health plans to provide states with information crucial to developing a comprehensive understanding of the status of the state's health care access and delivery systems;
- establishing a statewide employer mandate;
- imposing a level playing field through premium taxes on self-insured plans; and
- overseeing quality in self-funded health plans and establishing consumer protections.

(Source: National Governors' Association report on Private Sector Health Care Reform, 1997)

Grievance requirements of ERISA plans include disclosure of the grievance procedure in the summary plan document, the provision of a full and fair review of claims, and written notification to a beneficiary or subscriber whose claim has been denied. A claim denial notice must include the reason for the denial, and must be written in terminology understandable to the beneficiary. In addition, the beneficiary must be provided the opportunity to appeal the adverse decision to the fiduciary of the plan. If the adverse decision is reconsidered but not reversed, the beneficiary has limited recourse through the Department of Labor (DOL), as well as through federal court.

ERISA requirements can be classified as follows:

Reporting and disclosure requirements specify that plans must regularly report information on participants and finances to DOL. They must also disclose benefits, rights, responsibilities and other plan information to plan participants through a summary plan document.

Fiduciary standards encompass the investment and management of plan assets.

Claims procedures insure that plan participants and beneficiaries have remedies for violations of ERISA requirements, and are informed of these procedures.

(U.S. GAO, 1995)

U.S. Department of Labor: The DOL does not have authority to intervene in beneficiary grievances or to resolve disputes, but may provide individual assistance in the form of advising beneficiaries of their rights under ERISA, and providing general information regarding how federal law may apply to a beneficiary's situation. A 1995 General Accounting Office report notes that the DOL investigations of employer health plans are, in general, focused at the system level, and do not provide the level of individual complaint investigation provided by state insurance regulators (GAO, 1995).[1] The GAO also reports that, according to the National Association of Insurance Commissioners, ERISA does not provide for an unbiased review process external to the health plan, as state insurance regulators may provide.

Observation 1: The DOL may not provide, in general, the level of individual protections offered by states. However, it appears to offer some individual protections that the Virginia Department of Health (VDH) does not provide with regard to quality complaints. VDH does not currently provide individual assistance in the form of advising enrollees, members and subscribers of their rights, nor information regarding how state law may apply to a complainant's situation, as the DOL provides with regard to federal law. Medicaid clients are provided with individual assistance through the DMAS helpline and through the Enrollment Broker (Benova). Further, DMAS clients are provided with information regarding how state law may apply to them, in that at the time of enrollment and at the time of any adverse actions taken, Medicaid HMOs are required to notify clients in writing as to their rights under DMAS' Client Appeals regulations.

Federal Courts: Plan beneficiaries may also take unresolved disputes to federal court, but, here too, remedies are limited. While a claimant may prove that ERISA requirements have been violated, and thus receive the improperly denied benefit, the claimant cannot be awarded damages. For example, if the outcome of the "fair hearing and reconsideration" of the case in the nearby text box favors the claimant, she will be awarded the denied benefit and her attorney's fees. However, she cannot receive damages for "the months while in the hospital and year agonizing over a mounting debt created by case management's unrelenting pressuring her from afar to leave prematurely" (Business Wire, 1997).

Most states permit damage awards to claimants who were harmed as a result of the denied benefits, providing broader remedies than ERISA. Virginia does not

ERISA Plans: Recourse Through Federal Courts

A suit brought against Xerox Corporation by an employee in December 1991 was tried in September 1996. A senior judge in the U.S. District Court for the District of Connecticut delivered a Decision and Order against Xerox and its plan administrator for "arbitrary and capricious" behavior in denying payment for hospitalization to an employee. In this case, the managed care advisory firm hired by Xerox to control mental health care expenditures had denied payment for all but the first month of the employee's 4-month hospitalization. The court maintained that the plan administrator, by not providing an objective review of the beneficiary's claim, did not uphold her fiduciary responsibility to provide "a full and fair review" of denied claims as stipulated by ERISA. In speaking of the plan administrator's violation of her fiduciary duties, the court observed that "she made no independent effort to determine whether that decision was correct, she did not speak to (the employee) or her psychiatrist, she did not look at the medical record, and did not even consider seeking the advice of a third party." (Business Wire, 1997) The claim has been remanded to Xerox for a fair hearing and reconsideration.

[1] Currently, DOL's system-level protections do not include the classification and analysis of incoming complaint calls by type. In a recent teleconference, DOL Assistant Secretary Olena Berg reported that DOL receives approximately 50,000 calls per year relating to health plans, the majority of which relate to COBRA coverage. In her answer to a Virginia Department of Health question regarding complaint classification, Assistant Secretary Berg reported that DOL does not currently capture that data, but is interested in improving data collection efforts aimed at systematic analysis of complaints against ERISA health plans (Berg, 1997).

permit damage awards. It should also be noted that ERISA's limited awards may also discourage attorneys from accepting cases on a contingency basis (Dallek, 1995).

Collaborative Initiatives: While ERISA preempts many state laws, DOL has attempted to assist states' consumer protection efforts. DOL has filed "friend of the court" briefs with the intent of limiting the scope of ERISA preemption in areas in which ERISA has been interpreted too broadly. For example, briefs filed in some medical malpractice cases were successful in preventing HMOs from claiming exemption from state malpractice regulations on the basis of their being ERISA plans (Berg, 1997).

Consumers with employer-sponsored insurance are often unaware of the type of plan they have, and so may not know where to go for assistance with grievances. In some cases, plans may be self-funded but use a commercial insurer for administrative services, and consumers may wrongly think that they have commercial coverage with the requisite state protections. In other cases, consumers may understand that their plans are self-insured, but do not realize that the state has no jurisdiction over these plans. In both cases, consumers become aware, and frustrated, when they call the state insurance regulator with a complaint and find that little assistance can be offered at the state level. Moreover, consumers who go on to contact DOL discover that it does not provide the level of individual protections offered by most states. However, a pilot project between Oklahoma's Insurance Department (OID) and the U.S. Department of Labor was recently initiated to better address individual complaints. The agreement authorizes the Oklahoma Insurance Commissioner to "directly follow up with employers and plan administrators on participant assistance claims they receive dealing with self-funded health benefit plans" that are otherwise exempt from state regulation (U.S. DOL, OID, 1997). Under the agreement, the state may request information from employers and plan administrators regarding complaints, and refer still unresolved complaints to DOL's Pension and Welfare Benefits Administration (PBWA). OID and PBWA will also establish a system for tracking the number and types of referrals. OID gains no new powers, such as legal or investigative authority, from the agreement. The partnership is based on ERISA section 506, which permits the Labor Secretary to enter into cooperative agreements with state and federal agencies. The agreement with Oklahoma is the first state partnership.

Observation 2: In Virginia, non-Medicaid consumer complaint calls are most often received by BOI; those relating to ERISA plans are referred to the DOL. ERISA complaint volume is not currently being tracked by BOI.

Bureau of Insurance, State Corporation Commission: Oversight of Commercial Carriers *System level protections:* The State Corporation Commission's Bureau of Insurance (BOI) licenses and regulates all insurance carriers. Its major regulatory responsibilities include licensure of plans, licensure of insurance agents, regulation of plan solvency, oversight of marketing, advertising, sales and claims practices, and assurance of compliance with

§ 38.2-511. Failure to maintain record of complaints. — No person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under §38.2-1317 or during the last three years, whichever is the more recent time period. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

As used in this section, *"complaint"* shall mean any written communication from a policyholder, subscriber or claimant primarily expressing a grievance. (*Code* 1950, § 38.1-52; 1952, c. 317, § 38.1-52.10; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.)

state laws. State requirements regarding complaints against insurance carriers relate to disclosure, claims practices and record keeping.

As part of its market conduct examinations of all insurance carriers,[2] BOI obtains records of all complaints against a carrier since the previous market conduct examination, and reviews these records against BOI's own records of complaints received against the carrier. (The method by which BOI's own records are collected is described in the next section on individual protections.) The examination also includes a review of a statistical selection of complaints to determine if the complaints were handled in a timely manner and in conformance with applicable insurance laws and regulations. In addition to regularly scheduled market conduct examinations, BOI will also conduct targeted examinations when there is evidence of a particular problem, such as an egregious complaint or pattern of complaints.

It should be noted that, while state law contains requirements for complaints and grievances, only 'complaint' is defined in the *Code of Virginia* (Section 38.2-511). 'Grievance' is contained in that definition, but is not further defined.

Observation 3: The portion of the Code of Virginia applicable to BOI does not adequately define key concepts necessary to the oversight of complaint systems, such as 'inquiry', 'complaint', and 'grievance'. Of the three, only 'complaint' is defined in the Code in Section 38.2-511.

Individual level protections: BOI's records of health insurance complaints are generated as part of its process of handling inquiries and complaints from consumers regarding all types of insurance carriers. In the fiscal year ended June 30, 1997, the Life and Health Consumer Services Section of BOI handled approximately 3,700 inquiries and complaints against insurance carriers, the majority of which were health insurance complaints. Most of these complaints and inquiries are received from consumers[3] through the State Corporation Commission's toll-free hotline, (800) 552-7945.[4] The menu-driven system directs consumers with insurance concerns, including those relating to health insurance, to the Bureau's Life and Health Consumer Services Section. The role of the Life and Health Consumer Services Section is to communicate with insurers, advocate on behalf of consumers, and facilitate complaint resolution. It does not have authority to adjudicate those complaints which are based upon contractual interpretation, but often serves as an advocate to convince the insurer or HMO to modify its position. The complaint investigation process also serves as a mechanism for identifying violations of insurance laws. If the Life and Health Consumer Services Section determines that insurance laws may have been violated, BOI will

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[2]Section 38.2-1317.1 grants BOI authority to perform market conduct examinations. It states in part: "In scheduling and determining the nature, scope and frequency of examinations, the Commission shall consider such matters as the conduct of business in the marketplace,...".

[3]The section does not handle complaints from providers, with respect to relationships between providers and carriers. Providers advocating on behalf of patients are asked to have the complaint filed by the person insured.

[4]Section 38.2-305 of the *Code of Virginia* requires this toll-free number and BOI's address to appear on "each *new or renewal* insurance policy, contract, *certificate or evidence of coverage issued to a policyholder, covered person or enrollee*." (HB 2785 modified this section through the addition of the words in italics).

so indicate to the carrier as part of its advocacy for the consumer, and may also use its enforcement authority to initiate disciplinary proceedings against the carrier, as appropriate.

The Life and Health Consumer Services Section handles all complaints received until it is able to determine that a complaint is not within its regulatory purview. When it is determined that a complaint is not within the jurisdiction of BOI, the complainant is referred to the appropriate regulatory agency, such as DOL for ERISA complaints. Until recently, complaints involving quality of care in HMOs were pursued to the point where there was a clear difference of medical opinion as to the need for the disputed service. If the insurer or HMO maintained its position, the complainant was told that BOI could not resolve the issue in question. New procedures now provide that a complaint be evaluated early in the process, and if it involves quality of care in an HMO, that it is to be referred to VDH. Until recently, few complaints were forwarded, because prior Commissioners of Health did not handle quality of care complaints. More recently, collaborative efforts between BOI and VDH have improved the identification and referral of quality complaints. These collaborative efforts have been captured in an interim Memorandum of Agreement (MOA) between BOI and VDH. Discussion of this MOA, VDH's statutory authority for complaint investigation, and possible reasons for the previously low volume of referrals handled by VDH are included in the description of VDH individual protections below. It should be noted that VDH does not have authority for quality oversight of other forms of managed care. Therefore, when BOI's Consumer Services Section receives a quality complaint involving an insurance carrier that is not an HMO, it is unable to forward the complaint. There is currently no statutory or regulatory authority for VDH to address these complaints.

> *Observation 4: VDH has authority for quality oversight of HMOs, but not for other forms of managed care. Non-Medicaid subscribers and enrollees who call the BOI with quality complaints against managed care plans other than HMOs do not have their complaints addressed by the state under the current system. It should be noted, however, that Medicaid clients in the Medallion program (which is a non-HMO managed care program) do have a process for having their complaints addressed under the current system.*

Bureau of Insurance, State Corporation Commission: Oversight of HMOs

System level protections: BOI is granted much of the regulatory authority relating to HMO grievance systems. BOI's authority to regulate HMOs is specified in Title 38.2, Chapter 43 of the *Code of Virginia.* This regulatory authority includes oversight responsibility for enrollee complaint systems. Sections of the *Code of Virginia* relating to grievance systems authorize BOI to: 1) require that a description of the HMO enrollee grievance system be submitted with initial licensing and renewal applications; 2) require that the HMO's complaint system be described in the evidence of coverage[5]; 3) require that the HMO establish and maintain a complaint system for resolution of written complaints and submit an annual

[5]The evidence of coverage is defined in the *Code of Virginia* as "...any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled." In addition to a description of the grievance system, the evidence of coverage also includes descriptions of the health care services, insurance and benefits to which the enrollee is entitled, limitations on services and benefits (including co-payments and deductibles), information regarding how services are to be obtained, payment information, and conversion rights. A list of providers and a description of the service area is to accompany the evidence of coverage, if not previously given to the subscriber at enrollment.

complaint report to the oversight authority; 4) conduct an on-site financial examination of each HMO, including its complaint system, at least once every five years; 5) conduct market conduct examinations of HMOs;[6] and 6) establish "failure to implement a complaint system" as one of the conditions that may lead to suspension or license revocation. The sections of the *Code of Virginia* relating to enrollee grievance systems are excerpted and appear in Table 2. Sections of the *Virginia Administrative Code* relevant to this discussion are detailed in Table 3.

Table 2: Excerpts from the *Code of Virginia* Relating to HMO Grievance Systems

§ 38.2-4301. Establishment of health maintenance organizations. —
...B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:
...10. A description of the complaint system required in §38.2-4308;...

§ 38.2-4306. Evidence of coverage and charges for health care services. — A.
...4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:
...(e.) A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document, issued to the enrollee;...

§ 38.2-4308. Complaint system. — A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.
B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of complaints shall be maintained for the period set forth in §38.2-511.
C. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. However, at its discretion, the Commission may accept the report of examination conducted by the State Health Commissioner instead of making its own examination.

§ 38.2-4315 Examinations. — A. The Commission shall examine the affairs of each health maintenance organization as provided for in § 38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.
B. Instead of making its own examination, the Commission may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.
C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.
D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.
E. Instead of making its own examination, the Commission or State Health Commissioner may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of the state of domicile. (1980, c. 720, § 38.1-879; 1986, c. 562.)

[6]BOI attempts to conduct a market conduct examination of each HMO licensed in Virginia every 4-5 years, although there is no statutory requirement that this be done within a particular time frame.

Table 2: Excerpts from the *Code of Virginia* Relating to HMO Grievance Systems

§ 38.2-4316. Suspension or revocation of license. — A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:
...4. The State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth.
...7. The health maintenance organization has failed to implement the complaint system required by § 38.2-4308 to resolve valid complaints reasonably;...

§ 38.2-4318. License renewals. — A. Each health maintenance organization licensed under this chapter shall renew its license with the Commission annually by July 1. The renewal license shall not be issued until the health maintenance organization has paid all fees and charges imposed on it and has complied with all other requirements of law....

Table 3: Excerpts of the *Virginia Administrative Code* Relating to HMO Grievance Systems

14 VAC 5-210-70 (H) Grievance procedure.

1. Each health maintenance organization shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. A record of all written complaints shall be maintained for a period of at least three years.

2. Every health maintenance organization shall provide complaint forms and/or written procedures to be given to enrollees who wish to register written complaints. Such forms or procedures shall include the address and telephone number to which complaints must be directed and shall also specify any required time limits imposed by the health maintenance organization.

3. The grievance system shall provide for complaints to be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the health maintenance organization and the enrollee registering the complaint.

4. Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for the subscriber or enrollee for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made an effort to resolve the complaint and coverage is being terminated as provided for in subsection B of 14VAC5-210-80 of this chapter.

5. Where enrollee complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. No contract or evidence of coverage that entitles enrollees to resolve complaints and grievances through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more. If the enrollee agrees to binding arbitration his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.

Individual level protections: The Life and Health Consumer Services Section of BOI, handles consumer complaints regarding health insurance carriers, including HMOs.

Bureau of Insurance, State Corporation Commission: Oversight of Utilization Review Entities

In addition to grievance system standards and oversight, and complaint investigation management, the *Code of Virginia* also establishes requirements for utilization review (UR) standards and appeals.[7] UR entities subject to Title 38.2, Chapter 54 include HMOs, health insurers, hospital service corporations, health services plans and preferred provider organizations conducting utilization review solely for subscribers, policyholders, members or enrollees.[8]

> **§ 38.2-5300. Definitions.** — In this chapter and Chapter 54 (§ 38.2-5400, et seq.) Of this title, the following terms have the meanings indicated:
> *"Utilization review"* means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, health maintenance organization or other entity or person. For purposes of this chapter and Chapter 54 of this title, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services or any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital.

Chapter 54 does not apply to private review agents; they are subject to Chapter 53, which authorizes BOI to require private review agents to obtain a certificate to practice in the state. Private review agents applying for a certificate must meet certain minimum standards. They must provide descriptions of UR procedures, the patient and provider appeal process, the type and qualifications of personnel employed or contracted, and confidentiality mechanisms. It should be noted that the Department of Health Professions is conducting a study to determine whether UR agents who make prospective medical necessity determinations should be licensed in their professions and be subject to action by the relevant regulatory boards. The study will also consider alternative methods for assuring professional accountability in prospective medical necessity determinations.

System level protections: The oversight authority established under Section 38.2-5400, et seq. provides for grievance protections at the system level. Under Chapter 54, BOI is granted authority to determine whether a UR entity has complied with requirements to establish standards, to adopt a UR plan and to maintain records. However, BOI does not have authority to adjudicate controversies arising out of Section 38.2-5400, et seq. Chapter 54 is reproduced in Table 4.

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[7]As of 1996, Virginia was one of seven states to have implemented such a provision (Families USA, 1996). Since then, at least one other state (Colorado) has implemented UR standards and appeals.

[8]This statute applies to approximately 1,000 utilization review entities conducting business in Virginia.

Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*
§ 38.2-5401. Application to and compliance by utilization review entities—A. No utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this chapter. B. This chapter shall not apply to utilization review performed under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974. C. This chapter shall not apply to private review agents subject to Chapter 53 (§38.2-5300 et seq.) of this title. D. This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.
§ 38.2-5402. Requirements and standards for utilization review entities.—A. Each entity shall establish standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases. The entity shall make available to any provider, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws. B. An adverse decision shall be made only in accordance with §38.2-5406. C. Each entity shall have a process for reconsideration of an adverse decision in accordance with §38.2-5407 and an appeals process in accordance with §38.2-5408. D. Each entity shal' make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.
E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations. F. Each entity shall notify its covered persons of the review process, and shall so notify the covered person's provider upon written request by the provider. G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review. H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with §38.2-5404. I. The Commission shall have the right to determine that an entity has complied with the requirement that the entity establish requirements and standards pursuant to this section; however, the Commission shall have no jurisdiction to adjudicate controversies arising out of this section.
§ 38.2-5403. Utilization review plan required.—A. Each utilization review entity subject to this chapter shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of §38.2-5402 and other applicable provisions of this chapter. Such plan shall contain at a minimum the following: 1. Specific procedures to be used in review determinations; 2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment; 3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan; 4. A provision for a process for reconsideration of adverse decisions in accordance with §38.2-5407, and an appeals process in accordance with § 38.2-5408; and 5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of §38.2-5405. B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request. C. The Commission shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A; however, the Commission shall have no jurisdiction to determine the propriety of such plan.

Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*
§ 38.2-5404. Accessibility of utilization review entity.—A. A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern time zone shall provide covered persons advance written notification of the eastern time zone hours during which those entities are accessible; provided that such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours. B. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.
§ 38.2-5405. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information.—A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later. B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate. C. Each entity shall have reasonable access to patient-specific medical records and information. D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.
§ 38.2-5406. Adverse decision.—A. The treating provider shall be notified of any adverse decision within two working days of the decision. Any such notification shall include instructions for the provider to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number. B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. In any instance in which certification is questioned on the basis of medical necessity, at any time before the entity renders its decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity. C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.
§ 38.2-5407. Reconsideration of adverse decision.—A. Any reconsideration of an adverse decision shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel. The treating provider shall be notified of the determination of the reconsideration of the adverse decision, in accordance with § 38.2-5402, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting(s), if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to § 38.2-5408. B. Any reconsideration shall be rendered and the decision provided to the treating provider within ten working days of receipt of the request for reconsideration. C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*

§ 38.2-5408. Final adverse decision; appeal.—A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty working days after receiving the required documentation. The decision shall be in writing if so requested and shall state the criteria used and the clinical reason for the decision.

B. Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be a peer of the treating health care provider, must be board certified or board eligible, and must be specialized in a discipline pertinent to the issue under review. A physician advisor or peer of the treating health care provider who renders a decision on appeal shall: (i) not have participated in the adverse decision or any prior reconsideration thereof; (ii) not be employed by or a director of the utilization review entity; and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

C. The utilization review entity shall provide an opportunity for the appellant to present additional evidence for consideration on appeal. Before rendering an adverse appeal decision, the utilization review entity shall review the pertinent medical records of the covered person's provider and the pertinent records of any facility in which health care is provided to the covered person which have been furnished to the entity.

D. In the appeals process, due consideration shall be given to the availability or nonavailability of alternative health care services proposed by the entity. No provision herein shall prevent an entity from considering any hardship imposed by the alternative health care on the patient and his immediate family.

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis.

1. The decision on an expedited appeal shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor on the panel.

2. The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information. An expedited appeal may be requested only when the regular reconsideration and appeals process will cause a delay in the rendering of health care that would be detrimental to the health of the patient. Both providers and utilization review entities shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner. An expedited appeal decision may be further appealed through the standard appeal process established by the entity unless all material information and documentation were reasonably available to the provider and to the entity at the time of the expedited appeal, and the physician advisor reviewing the case under expedited appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

F. The appeals process required by this section does not apply to any adverse decision, reconsideration, or final adverse decision rendered solely on the basis that a health benefit plan does not provide benefits for the health care rendered or requested to be rendered.

G. No entity or insurer, health services plan, health maintenance organization or preferred provider organization performing utilization review pursuant to this chapter or Chapter 53 (§38.2-5300 et seq.) shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

H. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5409. Records. Every entity subject to this chapter shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Commission, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; review complaints received, including the manner in which the complaints were resolved; the number and type of adverse decisions, and reconsideration; the number and outcome of final adverse decisions and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records shall be maintained or caused to be maintained by the utilization review entity for a period of five years, and all such records shall be subject to examination by the Commission.

Comparison of HMO Grievance Provisions: Chapter 43 and Chapter 54

While managed care consumers theoretically have a multiplicity of issues that they may wish to grieve to their plan, adverse utilization review decisions are among the issues that are the most important to consumers. Whether the health plan has denied a service in advance, or refused to pay for a service after the fact, UR denials are very much at the heart of concerns about managed care protections. In Virginia, an enrollee of a commercial HMO[9] who receives an adverse decision from his plan can appeal the decision through the HMO's grievance system, or through his provider in accordance with the provisions of Chapter 54.[10] HMO grievance systems are addressed in Section 38.2-4308 and in administrative law at 14 VAC 5-210-70. These statutes and regulations address grievances in general and apply to any type of written complaint, including grievances about HMOs' utilization review decisions. On the other hand, the provisions of Chapter 54 specifically address appeals of utilization review decisions. Moreover, Chapter 54 applies not only to HMOs, but also to any insurer, health services plan, or preferred provider organization performing UR internally. The significant differences between UR appeals under Chapters 43 and 54 are discussed below.

Timeliness of Response: Chapter 54 defines an adverse decision as either a decision not to approve a proposed service, or a decision not to approve payment for a service already received. Section 38.2-5406(A) requires that the health plan making an adverse decision notify the treating provider within two days of the decision, and inform the provider of the procedure for requesting a reconsideration. Section 38.2-5407(B) requires that the health plan notify the provider of the result of the reconsideration within ten working days of the receipt of the reconsideration request. If the health plan decides against the provider, the decision becomes a final adverse decision, and may be appealed by the provider, the covered person, or his representative. Section 38.2-5408(A) requires the health plan to notify the appellant of the results of this appeal no later than sixty working days after receiving any required documentation.

Section 38.2-5408(E) provides for expedited appeals of adverse decisions or final adverse decisions within one business day of receipt by the health plan of all pertinent information. Expedited appeals may be requested by the treating provider when he or she believes that the adverse decision warrants an immediate appeal.

The time frames for response from the health plan in Chapter 54 are significantly shorter than the response time required of the HMO in the insurance regulations. 14 VAC 5-210-70(H)(3) requires that HMO complaints "be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered." Thus, an HMO enrollee will likely receive a much quicker response to an appeal of a utilization review decision if he appeals the decision in accordance with Chapter 54 rather than using the grievance procedures required by Chapter 43 and the regulations.

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[9]Chapter 54 is not applicable to Medicare HMOs or to programs administered by the Department of Medical Assistance Services, per Section 38.2-5401(C) and (D), respectively.

[10]Under Chapter 54, the covered person or his representative can appeal a *final* adverse decision.

Individual Bringing an Action: As currently stated in Section 38.2-5406(A), the UR entity must notify the treating provider of an adverse decision, and "shall include instructions for the provider to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number." Moreover, Section 38.2-5407(A) states that the treating provider is to be notified of the results of the reconsideration request (i.e.,the first level of appeal), and of the opportunity for a second level appeal. Section 38.2-5408(A) states that the appeal of an unfavorable reconsideration, or final adverse decision, may be brought by the HMO enrollee, his representative, or his provider.[11] Section 38.2-5408(E) indicates that a request for reconsideration of an adverse decision or a request for expedited appeal must be made by the treating provider.

There is no specified process for notifying the covered person of the adverse decision, or the reconsideration of the adverse decision. The covered person does not participate in the first level of appeal (the reconsideration of the adverse decision), but does participate in the second level of appeal (of the final adverse decision) if it does not require expedited handling.

With regard to Chapter 43, the insurance regulations prescribing HMO grievance systems address written complaints filed by a subscriber or enrollee only.

Access to UR Standards and Criteria: Section 38.2-5402(A) requires health plans to share UR criteria with *any* provider upon written request provided that copyright laws are not violated. While Section 38.2-5403(B) states explicitly that the UR *plan* shall be made available to covered persons upon written request, there are no provisions in Section 38.2-5402 for sharing UR criteria and standards with enrollees or their representatives.

The requirements for complaint systems in Chapter 43 and in the insurance regulations make no mention of UR criteria.

Disclosure of Process: Section 38.2-4306(A)(4)(e) entitles HMO enrollees to an evidence of coverage containing a description of the HMO's method for resolution of enrollee complaints. There is no requirement that the evidence of coverage contain any information on UR appeals. 38.2-5402(F) requires disclosure of the utilization review process to the covered person, but does not specify the method of disclosure. Section 38.2-5403(B) requires that the UR plan[12] and the appeals process be made available to providers and covered persons upon written request, specifying that it include the "portions of its utilization review plan relevant to the specific request."

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[11]Section 38.2-5404 and 5405 also explicitly include action by the covered person. Section 38.2-5404(A) requires that the UR entity be accessible to the covered person by telephone at least 40 hours per week. Section 38.2-5405(A) deals with emergency health care, and states that the covered person, his representative, or his provider may request authorization.

[12]The definition of "utilization review plan" in Chapter 54 is "...a written procedure for performing review."

Other Process Requirements: Chapter 54 requires that health plans provide two levels of appeal: the reconsideration request and the appeal of the final adverse decision. For complaint systems, neither the sections of the *Code* nor the regulations have any requirements regarding the levels of appeal. Additionally, Chapter 54 requires that reconsideration and appeals be reviewed by a peer of the treating health care provider. With respect to requirements for HMO complaint systems, no provisions are made in the *Code* or the regulations regarding the qualifications of the individuals reviewing the member's grievance.

Health Plan Reporting Requirements: Under Section 38.2-4308(B), HMOs are required to submit to the Commissioners of Health and Insurance an annual complaint report that includes a description of the procedures of the complaint system, the total number of complaints handled through the system, a summary of the causes for complaint, and information on malpractice claims settled or adjudicated that were brought against the HMO or any of its providers.

Section 38.2-5409 requires that utilization review entities keep records of utilization review standards and appeals for five years, that these records be accessible to the BOI, and that BOI may examine these records. The law does not require that these records be *submitted* to BOI, if requested. As previously noted, BOI does not have authority to adjudicate controversies arising out of Section 38.2-5400, et seq. BOI requested this language to exclude its involvement in issues of health care quality, and in contractual disputes between a plan and its providers. BOI's position on the former is that such disputes should be pursued in the court system. Regarding the latter, medical determinations relating to quality of care are outside the scope of BOI's insurance regulatory functions.

Observation 5: A commercial HMO enrollee wishing to grieve a utilization review decision has significantly different options, depending on whether the HMO grievance system or the provisions of Chapter 54 are used. The latter approach provides for a more rapid response, but requires the advocacy of his treating provider for the first level of the process, the request for reconsideration. Chapter 54 also permits the enrollee a representative. The requirements for HMO grievance systems do not recognize a representative or provider advocate. In addition, Chapter 54 requires a peer of the treating physician to review reconsideration and appeal requests, but no such requirements are in evidence for HMO grievance systems.

Observation 6: Utilization review standards and appeal legislation was passed in 1995, and requirements have now been in place for two years. Entities subject to Chapter 54 should now have two years' worth of information on UR review complaints received, their resolution, numbers and types of adverse decisions and reconsideration, numbers and outcomes of final adverse decisions and appeals, and separate records for expedited appeals.

Observation 7: Nearly 1,000 UR entities subject to Chapter 54 must make UR records available for review by BOI, but there is no requirement to submit records of utilization review complaints and appeals to BOI, if requested, or to VDH. No analysis of these data has been conducted. Moreover, medical necessity determinations under utilization review may be outside the scope of BOI's insurance regulatory functions.

Virginia Department of Health: Oversight of HMOs

VDH is charged with the responsibility for ensuring that medical care entities provide consumers with at least a minimum level of care according to regulations prescribed by the Board of Health and any additional requirements that may be specified in the *Code of Virginia*. In October 1996, the VDH Office of Health Facilities Regulation was administratively renamed the Center for Quality Health Care Services and Consumer Protection (hereafter called the "Center"). The Center continues to be the licensing agent for VDH. As directed by the *Code of Virginia*, the Board of Health adopts specific licensure regulations pertaining to medical care facilities and services, i.e., hospitals, outpatient surgical hospitals, nursing facilities, home health organizations, and hospice organizations.

Titles XVIII and XIX of the Social Security Act mandate the establishment of minimum health and safety standards which must be met by providers and suppliers participating in the Medicare and Medicaid programs. In order for medical facilities and services to receive Medicaid/Medicare funding, they must maintain compliance with the regulations promulgated by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

The Center inspects and licenses medical care facilities and services, conducts surveys for *federal certification*, conducts Medicaid inspections in institutions for the mentally retarded, and investigates complaints. Federal certification responsibilities include selected practitioners, which are noted in the nearby text box. Both state licensure and federal certification regulations are enforced by medical facilities inspectors who are VDH employees. Inspection activities, the most visible obligation of the Center, are used to satisfy both the state licensure requirements and federal certification requirements. In addition to regulatory compliance inspections, the Center investigates complaints made by the public regarding noncompliance with statutes and regulations. Where possible, the Center tries to administratively investigate complaints. More often, however, an on-site investigation is required to appropriately investigate the allegation. The Center is adapting its experience in facilities regulation to assume the new responsibility of oversight for the quality of care provided by HMOs and, perhaps, by other managed care organizations.

The VDH Center for Quality Health Care Services and Consumer Protection has oversight authority for the following:

State Facilities/Services/Programs

Home Care (80)	Hospitals(101)
Hospice (59)	Nursing Facilities (265)
Outpatient Surgical Hospitals (23)	

Selected Providers/Practitioners

Nursing Facilities (339)	Portable X-Ray (7)
Hospitals (109)	Rural Health Clinics (53)
Home Health (220)	Chiropractors (120)
Hospice (49)	Psychiatric Hospitals (15)

Community Mental Health Centers (7)
Ambulatory Surgical Centers (23)
Clinical Laboratories (3,792)
End Stage Renal Disease Facilities (102)
Comprehensive Outpatient Rehabilitation Facility (10)
Outpatient Physical Therapy/
Outpatient Speech Pathology (113)
Physical Therapy Independent Practice (101)
PPS Exclusion - Psychiatric Units (37)
PPS Exclusion - Rehabilitation Units (19)

System level protections: Some of the HMO oversight responsibilities granted to BOI under Title 38.2 Chapter 43 of the *Code of Virginia* are also granted to the State Health Commissioner. Section 38.2-4308(A), which grants BOI the authority to approve enrollee complaint systems, also requires HMOs to consult the State Health Commissioner in establishing their complaint systems.[13] HealthCommissioner, *shall* conduct examinations of Section 38.2-4308(B) requires HMOs to submit their annual complaint report to both BOI and the State Health Commissioner. Section 38.2-4308(C) grants authority for the examination of complaint systems; its language was amended by HB 2785, so that BOI, in cooperation with The StateHMO complaint systems.[14] BOI also may now accept the State Health Commissioner's examination in lieu of making its own examination. Finally, Section 38.2-4316(A) establishes that BOI may suspend or revoke an HMO's license if certain conditions exist. One of these conditions is certification by the State Health Commissioner that the HMO is unable to fulfill its duties to provide quality health services (Section 38.2-4316(A)(4)).

> *Observation 8: VDH and BOI do not have a formalized public process whereby the State Health Commissioner "certifies" that an HMO is in good standing with regard to fulfilling its duties to provide quality health services.*

In addition to this oversight responsibility, the State Health Commissioner was granted expanded authority to oversee HMOs' health service quality with the enactment of HB 2785. Prior to HB 2785, Section 38.2-4315(B) prescribed that the State Health Commissioner *may* examine HMOs' quality of health care services. With the signing of HB 2785, the *Code of Virginia* was amended with the addition of *Article 7. Review of Health Services Quality, § 32.1-122.10:01* to Chapter 4, Title 32.1 (See text box above). Under this law, the State Health Commissioner shall examine the quality of

[13]The mechanism for this consultation may not currently be clear to HMOs. Standardizing it and making communications public will therefore be included in the options to be discussed later in this document.

[14]Prior to this change, the language was "The Commission or the State Health Commissioner may examine the complaint system."

health care services of HMOs, and the providers with whom they conduct business. As a result, Section 38.2-4315(B) was amended to include only BOI's authority to conduct HMO examinations. In addition, both Section 32.1-122.10:01 and Section 38.2-4315(B) now contain subsections which prescribe that BOI and the State Health Commissioner will coordinate examinations "to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation."

> *Observation 9: HMO examination expenditures referred to in Section 32.1-122.10:01(C) include salary, travel, lodging, and meals. They do not allow for reasonable costs associated with non-personnel expenditures and complaint investigations, nor is the current mechanism adequate for funding the Center's newly added responsibilities.*

HMOs are required to maintain complaint data and must submit to both the Commissioner of Health and the Insurance Commissioner an annual complaint report which includes the total number of complaints and their underlying causes.

> *Observation 10: There is variability among Virginia HMOs in the form of the information contained in their complaint reports. For example, complaint classifications, the relative proportions of complaints by classification, and the level of detail provided varies among HMOs.*

VDH has authority to examine HMO grievance systems pursuant to licensure through the *Code of Virginia* and through the Memorandum of Agreement with BOI. In addition, complaint reports are reviewed annually. However, there have been no administrative regulations promulgated to give VDH the authority to impose sanctions on HMOs and currently VDH can only make recommendations to BOI for sanctions.

> **§ 32.1-122.10.01 Review of health maintenance organizations.**—A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§ 38.2-4301 and 38.2-4302 and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.
> B. For purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.
> C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.
> D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.
> E. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in § 38.2-4308; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § 38.2-4308; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § 38.2-4308.
> F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

> *Observation 11: Although VDH and BOI examine HMO complaint systems and annual complaint reports, neither has the authority to impose sanctions on an HMO on behalf of an individual in response to a specific complaint that has been investigated and found to have merit.*

Individual protections: As discussed earlier, of the written complaints received by BOI in fiscal year 1996 relating to health insurance, there were fewer than 15 referrals of HMO complaints to the Center. The Center also received about 10 complaint calls directly from consumers last year. This may be attributable to several possible causes. Low complaint volume may be an indication that there is not great need. However, it is more likely that consumers with unresolved grievances are unaware that this resource exists. The most likely explanation is that, until 1997, VDH had no formal procedures in place to respond to complaints forwarded by BOI, and discouraged BOI from forwarding such complaints. Moreover, BOI's criteria for identifying quality of care complaints may have excluded some complaint types. These issues have since been addressed as part of the collaborative initiative between BOI and VDH. Now included in the complaint resolution procedures developed by the Center are detailed screening criteria for use by BOI in triaging incoming complaints. Major classifications are "access to health care services," "utilization management," and "practitioner/provider issues." Detailed criteria are provided in Attachment I.

Section 32.1-122.10.01(E) requires the Health Commissioner to "review and analyze HMOs' complaint reports" pursuant to Section 38.2-4308(B) and to assist the Insurance Commissioner in the examination of complaint systems, pursuant to Section 38.2-4308(C). However, the authority for VDH to initiate an examination as a result of an individual complaint or pattern of complaints is not currently granted in statute.

> *Observation 12: While authority for the examination of complaint systems is granted to VDH in Section 38.2-4308(C), the authority for examinations resulting from an individual enrollee complaint or pattern of complaints is not explicitly stated in Section 32.1-122.10.01.*

The Provider Focused Roundtable (May 6, 1997) and Consumer Focused Roundtable (May 23,

Complaints tracked by the Center for Quality Health Care Services and Consumer Protection (CQHCCP) between December 9, 1996 and July 21, 1997

Total Complaints received:	31
Complaints concerning access:	6
Complaints concerning utilization review:	16
Complaints concerning practitioners/providers:	4
Complaints that are non-jurisdictional:	5

Mechanisms through which complaints were submitted

Referral made by the Bureau of Insurance:	23
Referral made by the State Health Commissioner:	2
Referral made by the Medical Society of Virginia:	2
CQHCCP contacted by telephone:	3
CQHCCP contacted by mail:	1

Of the 31 total complaints, 26 were submitted by the enrollee and 5 complaints were submitted by the enrollees' attending physician.

Breakdown of Complaints concerning Utilization Review (*n*=16)

Denial of medically appropriate services:	8
Limitation on hospital length of stay:	4
Denial of specialist referrals:	1
Timeliness of preauthorized reviews:	1
Other:	2

- Pre-existing condition
- Denial of selection of where to purchase contacts

Closed complaints resolved as follows:

HMO resolved, treatment received to the satisfaction of the enrollee:	3
Physician withdrew the complaint; did not want to involve the patient:	1
HMO conducted appropriate investigation and followed company policy and procedures including contract:	1
Referred to another state as HMO was not licensed in Virginia:	1

1997) conducted by the HB 2785 Study Group indicate that consumers and the providers who advocate for them are frequently uninformed or confused about the protections afforded them by the state. However, preliminary evidence from the formalized complaint resolution process and the collaborative initiative between VDH and BOI indicate that consumers are slowly becoming more aware of existing consumer protections, and are beginning to make their quality concerns known to VDH, either directly or through BOI. The Center has received 32 referrals from BOI in the two months since the referral process was formalized, and has consulted with BOI on additional calls which were not referred. Thus far, the Center reports that many of these calls are inquiries that involve providing information and educating consumers about their plans. These inquiries differ from complaints and grievances, in that corrective action is not yet warranted or requested. Moreover, some inquiries, as well as complaints calls, may be outside the purview of the Center's current authority (e.g., calls relating to preferred provider organizations (PPOs).

Observation 13: Evidence from the Center's formal complaint process suggests that consumers are seeking information and education, in addition to complaint assistance. (The HB 2785 Consumer and Provider Focused Roundtables also corroborated that consumers and the providers who advocate for them are in need of information and education regarding the existing state protections available to them.)

Observation 14: Consumers in PPOs and other forms of managed care are requesting information and assistance through the Center. However, the Center has no statutory authority to investigate quality of care complaints in PPOs, and other forms of managed care.

Collaborative Initiatives: Because of the low number of quality complaints received by the Center, it has begun to step up collaborative efforts with staff at BOI. The interim Memorandum of Agreement (MOA) between VDH and the SCC creates new opportunities for better data collection, complaint identification, and coordination between the agencies. Included in these coordinated functions are participation in BOI's market conduct examinations of HMOs, and in system level reviews of HMO complaints made by consumers and providers. The Center staff will also be able to respond to questions and provide assistance to other managed care consumers and to those with traditional indemnity insurance, should authority for this activity be granted, and resources become available. The MOA provides a flexible arrangement under which VDH and BOI can share respective expertise to research the types of quality assurance mechanisms that are necessary, so as to construct an oversight system that is the least intrusive for the industry.

This commitment to collaboration and coordination among state agencies has been further recognized through a recent National Academy for State Health Policy grant. This two-state demonstration grant was awarded to Virginia and Colorado to improve the quality of health care that low income women and children receive by improving collaboration and coordination among the state agencies responsible for oversight of Medicaid managed care. The three state agencies involved in Virginia—the Department of Medical Assistance Services, the Bureau of Insurance and the Department of Health—have established the project team and developed a work plan.

Department of Health Professions: Oversight of Health Care Practitioners

The mission of the Department of Health Professions (DHP) is to assure safe and competent delivery of health care to citizens of the Commonwealth. Major activities include licensing, promulgating rules governing practice and taking disciplinary action. These responsibilities are accomplished through the operation of health regulatory boards. Ten of these twelve boards have statutory authority to issue licenses and certificates to providers whose clinical practices are often conducted in managed care settings. As of March 31, 1997, the number of practitioners currently credentialed was 220,347. Of these, 178,415 were resident in the Commonwealth. Licenses issued by these regulatory boards are required for legal, valid practice in the Commonwealth, and misdemeanor or felony prosecution can be sought for unlicensed practice[15] or practice subsequent to licensure suspension or revocation[16].

The following DHP boards have oversight authority for practitioners who may practice in managed care settings*:

Audiology and Speech Language Pathology
Dentistry
Medicine
Nursing
Nursing Home Administrators
Optometry
Pharmacy
Professional Counselors and Marriage and Family Therapists
Psychology
Social Work

* The Boards of Funeral Directors and Embalmers, and Veterinary Medicine are excluded from this discussion.

Jurisdiction of DHP extends to health care practice regardless of reimbursement or organization of a health care plan. For all practitioners, regulatory boards may impose a reprimand, fine, probation with specific terms or conditions of practice, or a suspension or revocation of a license, certification or registration. Parties to disciplinary proceedings include the Commonwealth and the practitioner. Action may be taken against an applicant or the holder of an expired license.

Complaint and Report System: DHP receives information regarding alleged licensee violation of laws or regulations from a variety of sources, including health care consumers, coworkers, other licensees, government agencies, managed care entities, health care institutions, employers, insurance companies, and courts. The complaint intake unit of DHP's Enforcement Division receives the incoming complaint information, which may be conveyed in writing, through a call to the toll free complaint "hotline", or through a personal visit to the agency. The information is recorded and subsequently reviewed by an analyst to determine whether the alleged activity falls under the jurisdiction of the laws

[15]Section 54.1-111

[16]Section 54.1-2409

regulations of a regulatory board; review is conducted irrespective of payment source or practice site in which the related health care service was rendered.[17] When initial review indicates that the complaint does not fall under the jurisdiction of a regulatory board, or represent a violation of a law or regulation of these boards, but may fall under the jurisdiction of another state agency, such as BOI or VDH, the information is forwarded to that state agency. When initial review demonstrates that this information is within DHP's jurisdiction and represents grounds for possible action, an investigation is initiated; the priority level and time standard for completion are established based upon the potential danger to public or patient health and safety. In all cases, DHP provides the information source with an explanation of the initial review results.

Investigation of Report: Investigative staff of the four field regions and central administrative unit of the Enforcement Division receive specialized health care investigative training. Most investigators have either law enforcement or health care experience; some are current licensees of a health regulatory board. An investigation is conducted commensurate with case priority as well as case load of the assigned investigator, and includes interviews (i.e., information source, witnesses, accused licensee), and the collection of medical records and other evidence necessary to address the alleged violation(s). The department has broad investigative subpoena power. Investigation findings are provided to the appropriate regulatory board for consideration and action via a formal investigative report. The investigator also informs the information source of the ongoing status of the investigation, and notifies the source when the report has been forwarded to the appropriate board. If evidence indicates that a criminal law may have been violated, the investigator will work with law enforcement agencies; however, actions by the boards and the criminal justice system are taken separately.

Total Complaints from All Boards in 1996—3,233

Total Investigations Initiated for All Boards—1,658 (51% of all complaints)

Nature of All Complaints Investigated

Unprofessional Conduct	841	51%
Substandard Care	661	40%
17 Other Categories	156	9%
Total	1,658	100%

Sources of All Complaints Investigated

Required Reports	626	38%
Consumers	427	26%
Other Sources	518	31%
Anonymous	87	5%
Total	1,658	100%

Volume of Investigations by Board *

Nursing	607	40%
Medicine	524	34%
Dentistry	160	10%
Pharmacy	116	8%
All others	128	8%
Total	1,535	100%

* Includes only the 10 DHP boards under discussion. (47% of total complaints received; 93% of total investigations)

[17]Information alleging unlicensed practice of one of the health professions may result in a DHP investigation for the Commonwealth, even though none of the health regulatory boards has specific jurisdiction, with subsequent referral of the investigative report to a Commonwealth's attorney for prosecutorial consideration.

Board Review of Investigation, Case Decision: Upon Board receipt of an investigative report, a review is conducted to determine whether probable cause exists and charges should be made against a licensee. If the evidence is not sufficient, the case is closed, and the information source and licensee are notified. When probable cause is found, a notice of hearing or, in a limited number of cases, a pre-hearing consent agreement offer are issued to the licensee.[18] A public proceeding—an informal conference and/or a formal hearing—then follows, unless there is agreement for a consent offer. The information source is also notified. During this proceeding, the board, or a committee of the board, decides whether a violation of law or regulation has taken place, and if so, what disciplinary action or sanction will be imposed.

Currently, an exception to the process described above is permitted by some, but not all, boards when the evidence indicates that practitioner conduct represents a "substantial danger to the public health or safety." In these cases, a board may impose a summary suspension of that license. A formal hearing must be conducted after a summary suspension. Effective July 1,1997, all boards will have authority to issue summary suspensions. The law also provides for indefinite licensure suspension by the Director of DHP when the licensee has been convicted of a felony, has had his license revoked or suspended in another jurisdiction, or pays for a license with a dishonored check. A court, under certain circumstances, may suspend a license for non-payment of child support. Final board orders are almost always public documents, and they become part of the licensee's official, permanent licensing record. Of the investigations completed for, and considered by, these ten regulatory boards in 1996, 729 (47.5%) of these resulted in some type of disciplinary sanction, ranging from license/certificate revocation (approximately 8% of all disciplinary action) to a reprimand or warning (approximately 34%).

Examples of laws and regulations of the boards relating to professional practice standards are summarized below, according to several, more specific, categories.

Licensing/Credentialing: Statutory provisions require licensure[19] of 23 different types of health care practitioners under these ten regulatory boards, and regulation through certification of an additional 6 health care occupations,[20] and provide authority to establish competency standards, screen and issue licenses, receive and evaluate complaints against licensees, and issue disciplinary sanctions, including licensure revocation, against licensees. Boards are assisted in the detection of licensee practice problems through Section 54.1-2906, and Section 54.1-2907,[21] which

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[18]Currently, some, but not all, Boards may make exceptions to these procedures if evidence indicates that practitioner conduct poses a "substantial danger to the public health or safety". The summary suspension that may be issued in these cases is discussed in the next paragraph.

[19]§ 54.1-102, 106, 111, 2409.1, 2603, 2709, 2710, 2711, 2714.1, 2715, 2722, 2723, 2725, 2726, 2902, 2929, 2942, 2956.8.9, 3008, 3102, 3204, 3310, 3506, 3606, 3706, *The Code of Virginia*, 1950, as amended.

[20]§54.1-2954, 2956, 3022, 3008, *The Code of Virginia*

[21]Section 54.1-2907 applies to providers treating other providers, and so is not reproduced in this document.

both set out requirements under which health care institutions and providers must report specified circumstances.

Section 54.1-2906 is reproduced on the following page..

§ 54.1-2906 of the *Code of Virginia*

§ 54.1-2906. Hospitals and other health care institutions required to report disciplinary actions against and certain disorders of health professionals; immunity from liability.— *A. The chief administrative officer and the chief of staff of every hospital or other health care institution in the Commonwealth shall report to the appropriate board the following information regarding any person licensed by a health regulatory board unless exempted under subsection D:*

1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or at any other health care institution, for treatment of substance abuse or a psychiatric illness which may render the health professional a danger to himself, the public, or his patients.

2. Any information of which he may become aware in his official capacity indicating that such health professional may be guilty of unethical, fraudulent, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

3. Any disciplinary action, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges, while under investigation or during disciplinary proceedings, taken or begun by the institution as a result of conduct involving professional ethics, professional incompetence, moral turpitude, or substance abuse.

4. The voluntary resignation from the staff of the health care institution or voluntary restriction or expiration of privileges at the institution of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.

Any report required by this section shall be in writing directed to the secretary of the appropriate board, shall give the name and address of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported. Any report required by this section concerning the commitment or admission of such health professional as a patient shall be made within five days of when the chief administrative officer learns of such commitment or admission.

The provisions of § 8.01-581.17 shall not bar (i) any initial report required by this section or (ii) any requested medical records which are necessary to investigate unprofessional conduct reported pursuant to this subtitle or unprofessional conduct that should have been reported pursuant to this subtitle.

B. The State Health Commissioner shall report to the appropriate board any information of which the Department of Health may become aware in the course of its duties indicating that such a health professional may be guilty of fraudulent, unethical, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

C. Any person making a report required by this section or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

D. Medical records or information learned or maintained in connection with an alcohol or drug prevention function which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 21 U.S.C. § 1175 (a), 42 U.S.C. § 4582 (a), or regulations promulgated thereunder.

Observation 15: Section 54.1-2906(A) requires that hospitals and other health care institutions report to DHP any of the disciplinary actions or health conditions specified in Section 54.1-2906(A), items 1-4, regarding the practitioners with whom they contract. While HMOs and other managed care organizations contract with practitioners, they are not required by statute to report such problems to DHP.

DHP is conducting a study regarding the applicability of licensing to UR agents who perform prospective utilization review. Currently, UR agents must obtain certification pursuant to *Title 38.2,* Chapter 53, of the Code of Virginia.

Professional Conduct: Standards for professional conduct expected of licensees of a board exist either in statute or board-established regulation. For example, Section 54.1-2914, under the Board of Medicine, outlines 16 activities considered unprofessional for practitioners of the healing arts regulated by this board, including.... "Conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts"[22]; ... "Conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public"[23]; or, "Performs any act likely to deceive, defraud or harm the public"[24].

Process to Appeal a Board Decision: A licensee may appeal a board's decision in the disciplinary matter to a Circuit Court, which may uphold, suspend or set aside the decision or remand the matter back to the board for further proceedings. Appeals of action are relativity infrequent—less than ten per year. The licensee may appeal a Circuit Court's decision to the Court of Appeals, which has the same ruling options as the Circuit Court.

Department of Medical Assistance Services: Oversight of Medicaid Programs

As of June 1997, the Department of Medical Assistance Services (DMAS) has three managed care programs operational in the Commonwealth, serving about 300,000 beneficiaries. Medallion is a primary care case management program in which Medicaid clients are assigned to a primary care physician (PCP) who is paid a monthly case management fee in addition to fee-for-service. The PCP acts as a gate-keeper and must refer clients for most health services delivered outside of the PCP's office. Medallion includes most Aid to Families with Dependent Children (ADC) and Aged, Blind and Disabled (ABD) clients, and is operational state-wide except for the seven Tidewater cities in the Medallion II project.

Medallion II, implemented January 1, 1996, is a mandatory HMO enrollment program for most ADC and ABD clients in Hampton, Newport News, Poquoson, Norfolk, Portsmouth, Virginia Beach and Chesapeake. In these cities, DMAS is contracted with four HMOs to provide all covered Medicaid services to eligible enrollees. As of June 1997, enrollment in Medallion II was approximately 86,000.

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[22]Section 54.1-2914(A)(9)

[23]Section 54.1-2914(A)(10)

[24]Section 54.1-2914(A)(13)

The *OPTIONS* program was implemented in January 1995 and offers ADC and ABD clients a choice of the Medallion program or a contracted HMO. *OPTIONS* is operational in the metropolitan areas of Northern Virginia and Richmond.

The quality oversight systems for Medicaid managed care populations have developed from the early 1990s and are driven by both state and federal influences. The Virginia General Assembly directed DMAS to develop a mandatory managed care program for Virginia in 1995. In order to establish the mandatory managed care program, DMAS then had to obtain a waiver from the federal Health Care Financing Administration. The terms of the waiver require certain quality oversight systems, including periodic independent assessments of the program's quality and cost effectiveness, as well as annual quality reports on the performance of each Medicaid HMO, as prepared by an Independent External Quality Review Organization. More recently, VDH began exercising its statutory prerogatives for licensed HMOs in April of 1996. Thus, oversight for the quality of care in HMOs for commercial and Medicaid populations have emerged somewhat independently in Virginia.

Complaints: In August 1996, DMAS contracted with an enrollment broker to serve three functions: client enrollment in HMOs and PCP selection assistance for the Medallion program; client education regarding managed care and HMO selection; and operation of a client help line. Benova, Inc., the contracted enrollment broker, receives and documents complaints received from Medicaid managed care clients.

All contracted HMOs are required to record and track complaints and to submit quarterly summaries of the complaints received from DMAS clients. Beginning in 1997, DMAS implemented uniform complaint reporting with a requirement that all contracted HMOs use the same form for complaint summaries.

In addition to HMOs and the enrollment broker, internal agency staff may handle complaints from DMAS clients. DMAS has a special complaint form used for these complaints. DMAS then compiles all client complaints received via the above-referenced sources (enrollment broker, HMOs, and DMAS helpline). A system is under development whereby these complaints shall be tracked and analyzed by the Division of Policy and Budget. A system is also under development whereby complaints received by the DMAS helpline are being entered directly into a database that will allow for the identification of trends and similar analysis.

When complaints from clients concern specific episodes of care, DMAS may request that the External Quality Review Organization (EQRO) investigate the complaint in order to determine whether the client received appropriate care. The EQRO, as previously indicated, is under contract with DMAS to perform periodic medical audits/quality reviews, in fulfillment of HCFA requirements.

Grievances and Appeals: DMAS has established a formal appeals process for all Medicaid beneficiaries whereby any Medicaid client enrolled in an HMO may file an appeal directly to the HMO and/or to DMAS. The

oversight and administration of this process is carried out by the 28 staff members that comprise the DMAS Division of Appeals. The Division is made up of a director, two managers, twelve hearing officers for recipient appeals (HMO appeals are all recipient appeals), two administrative hearing representatives for formal provider appeals, five informal appeal agents for provider appeals, one legal assistant, and five support staff.

Under the system that has been instituted, any Medicaid client enrolled in an HMO may file a formal (i.e., written) grievance in response to an action taken by an HMO that denies, terminates or reduces services. The grievance must be filed within 30 days of the action, unless there exists "good cause" to prevent a timely filing [25].

Any HMO receiving such a formal grievance is required to provide a copy of the grievance to DMAS within two business days[26]. Further, the HMO is required to issue a decision on the matter within 14 days[27]. A copy of the HMO's decision on the formal grievance is to be provided to DMAS and the client concurrently[28].

All of the formal grievance requests are logged by DMAS as appeal requests. If the HMO reaches a decision fully favorable to the client within the allotted 14 days, a DMAS hearing officer will administratively resolve the appeal. If DMAS has not been notified of the HMO's decision by the 16th day, or the HMO does not reach a fully favorable decision, DMAS will proceed with the process of contacting the appellant and scheduling a hearing. An informal hearing is then held and a decision is issued by the DMAS hearing officer. Note that this decision must be issued within 90 days of the date of the written grievance request, and that pursuant to the recent United States District Court case of Daniels v. Wadley, this period is determined from the time that the original grievance is made to the HMO. The decision of the DMAS hearing officer is binding and is the Commonwealth's final administrative action. The appellant has the authority, under Rule 2A:2 of the Virginia Supreme Court and the Recipient Appeals Regulations, to appeal the decision to Circuit Court.

As stated previously, DMAS, BOI, and VDH are currently studying ways to improve the quality of care for low income woman and children (and children with special needs) through efficient interagency collaboration. One area that has been studied is the overlapping responsibilities for oversight of the grievances filed by this population.

> ***Observation 16:*** *The complaint classification schemes for quality of care concerns in Medallion II and in commercial oversight are dissimilar. However, a system is currently under development for classifying complaints with a classification scheme based upon the categories used by VDH.*

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[25] 12VAC30-120-420 A & B

[26] 12VAC30-120-420 F

[27] 12VAC30-120-420 H

[28] 12VAC30-120-420 I

U.S. Health Care Financing Administration: Oversight of Medicare Programs

The U.S. Health Care Financing Administration (HCFA) requires that peer review organizations (PROs) perform mandatory case review of all beneficiary complaints concerning quality of care, regardless of the setting, and of all complaints alleging patient dumping, regardless of the source of the complaint. Additionally, the PRO reviews cases involving hospital- or managed care plan-issued notices of noncoverage where the beneficiary is 100% liable for the cost of care. Another independent entity—the Center for Dispute Resolution—reviews all other non-coverage and medical necessity determinations. Any referrals from HCFA, the Office of the Inspector General (OIG), intermediaries, carriers, or the managed care appeals contractor must also be reviewed by the PRO; the scope of the review is determined by the nature of the referral. If the PRO discovers, during the course of routine review or focused study, a problem indicating potential "gross and flagrant" violation of standards of care or unnecessary admission, the PRO must also investigate this.

There are 4,000 Medicare-eligible Virginians who receive care through Medicare HMOs (VAHMO, 1997). Virginia's PRO, the Virginia Health Quality Center (VHQC), administers the case review process for these beneficiaries, as well as all Virginians who have Medicare fee-for-service. VHQC reviews written complaints received from Medicare managed care enrollees, as well as calls received on VHQC's hotline. VHQC has the authority to issue an improvement action on the provider, and may impose sanctions through HCFA.

As discussed earlier in this document, VDH participates with BOI in the market conduct examination of HMOs, pursuant to the BOI/VDH interim Memorandum of Agreement. As part of this process, the VDH Center for Quality Health Care Services and Consumer Protection examines complaint records, including those of Medicare beneficiaries enrolled in the HMO under review. At the conclusion of each site survey, the Center's inspector also reviews the report of the latest HCFA-contracted inspection. If there are any material differences, these are noted by the Center's inspector, and are forwarded to HCFA.

Department of Personnel and Training: Oversight of State Employee Health Benefits Program

The State Employee Health Benefits Program, administered by the Department of Personnel and Training (DPT), offers two statewide managed care plans and a number of HMO plans which are each available in one or more regions of the state. The two statewide plans, Key Advantage and Cost Alliance, are self-insured, ERISA-exempt plans that are administered by Trigon Blue Cross Blue Shield. DPT is responsible for plan oversight, and, as such, neither BOI nor VDH have any oversight authority relating to these plans.[29] The HMO plans offered through the program are fully insured. Thus, BOI and VDH, as well as DPT, have oversight responsibility.

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[29]BOI regulates insurance carriers, but not insurance activity that is incidental to the primary purpose of an organization. The Commonwealth is not in the business of insurance.

All employees and family members covered in the State Group have available to them an appeals procedure through their plan. There is a description of each plan's appeals process in the plan member handbook, which is distributed to each enrolled employee. If an individual considers a dispute unresolved after the plan's appeals process has been exhausted, the member may exercise his or her right to an executive appeal to the Director of DPT. Upon receipt of an executive appeal, there is an analysis to assure that the complainant has received due process through the plan's appeals procedures. The DPT review is not a de novo determination; however, DPT does explore quality issues to secure resolution through formal or informal means. Executive appeals must be received in writing and the response returned in writing.

Observation 17: The State Employee Health Benefits program handles complaints for state employees enrolled in HMOs. However, their valuable data on complaints would be lost if SEHBP did not work collaboratively with the BOI, VDH, DHP, and DMAS to adopt screening criteria, record and track the complaint according to the screening criteria in this report.

Office of the Attorney General: Consumer Representation (No Direct Oversight Role)

As previously mentioned, the Office of the Attorney General does not have a direct role in grievance system oversight. However, the Division of Consumer Counsel within the Office of the Attorney General is charged with representing consumers before governmental departments, commissions and agencies. Section 2.1-133.1 of the Code of Virginia provides the authority for the establishment of the Division of Consumer Counsel. Cases handled by the Division are those affecting many consumers. The Division does not investigate individual health insurance complaints, but does refer such complaints to BOI's Life and Health Consumer Services Section (JCHC, 1996).

IV. SUMMARY OF OBSERVATIONS

Observation 1 (p. 6)

The DOL may not provide, in general, the level of individual protections offered by states. However, it appears to offer some individual protections that the Virginia Department of Health (VDH) does not provide with regard to quality complaints. VDH does not currently provide individual assistance in the form of advising enrollees, members and subscribers of their rights, nor information regarding how state law may apply to a complainant's situation, as the DOL provides with regard to federal law.

Observation 2 (p. 7)

In Virginia, consumer complaint calls are most often received by BOI; those relating to ERISA plans are referred to the DOL. ERISA complaint volume is not currently being tracked by BOI.

Observation 3 (p. 8)

The Code of Virginia does not adequately define key concepts necessary to the oversight of complaint systems, such as 'inquiry', 'complaint', and 'grievance'. Of the three, only 'complaint' is defined in the Code.

Observation 4 (p. 9)

VDH has authority for quality oversight of HMOs, but not for other forms of managed care. Subscribers and enrollees who call the BOI with quality complaints against managed care plans other than HMOs do not have their complaints addressed under the current system.

Observation 5 (p. 18)

A commercial HMO enrollee wishing to grieve a utilization review decision has significantly different options depending on whether he uses the HMO grievance system or the provisions of Chapter 54. The latter approach provides for a more rapid response, but appears to require the advocacy of his treating provider for the first stage of the process, the request for reconsideration. Chapter 54 also permits the enrollee a representative. The requirements for HMO grievance systems do not recognize a representative or provider advocate. Chapter 54 requires a peer of the treating physician to review reconsideration and appeal requests, but no such requirements are in evidence for HMO grievance systems.

Observation 6 (p.18)

Utilization review standards and appeal legislation was passed in 1995, and requirements have now been in place for two years. Entities subject to Chapter 54 should now have two years' worth of information on UR review complaints received, their resolution, numbers and types of adverse decisions and reconsideration, numbers and outcomes of final adverse decisions and appeals, and separate records for expedited appeals.

Observation 7 (p. 18)

Nearly 1,000 UR entities subject to Chapter 54 must collect and make UR records available for review by BOI, but there is no requirement to submit records of utilization review complaints and appeals to BOI, if requested, or to VDH. No analysis has been conducted on these data. Moreover, medical necessity determinations under utilization review may be outside the scope of BOI's insurance regulatory functions.

Observation 8 (p. 20)

VDH and BOI do not have a formalized public process whereby the Health Commissioner "certifies" that an HMO is in good standing with regard to fulfilling its duties to provide quality health services.

Observation 9 (p.21)

HMO examination expenditures referred to in Section 32.1-122.10.01(C) include salary, travel, lodging, and meals. They do not allow for reasonable costs associated with non-personnel expenditures and complaint investigations, nor is the current mechanism adequate for funding the Center's newly added responsibilities. The current mechanism is inadequate to provide sufficient resources to implement new responsibilities.

Observation 10 (p.21)

There is variability among Virginia HMOs in the form of the information contained in their complaint reports. For example, complaint classifications, the relative proportions of complaints by classification, and the level of detail provided varies among HMOs.

Observation 11 (p.21)

Although VDH and BOI examine the complaint systems and the annual complaint report, neither has the authority to impose sanctions on an HMO on behalf of an individual in response to a specific complaint that has been investigated and found to have merit.

Observation 12 (p. 22)

While authority for the examination of complaint systems is granted to VDH in Section 38.2-4308(C), the authority for examinations resulting from an individual enrollee complaint or pattern of complaints is not explicitly stated in Section 32.1-122.10.01.

Observation 13 (p. 23)

Evidence from the Center's formal complaint process indicates that consumers are seeking information and education, in addition to complaint assistance. The HB 2785 Consumer and Provider Focused Roundtables also indicate that consumers and the providers who advocate for them are in need of information and education regarding the existing state protections available to them.

Observation 14 (p. 23)

Consumers in PPO's and other forms of managed care are requesting information and assistance through the Center. However, the Center has no statutory authority to investigate quality complaints in PPOs, and other forms of managed care.

Observation 15 (p. 27)

Section 54.1-2906(A) requires that hospitals and other health care institutions report to DHP any of the disciplinary actions or health conditions specified in Section 54.1-2906(A), items 1-4, regarding the practitioners with whom they contract. While HMOs and other managed care organizations contract with practitioners, they are not required by statute to report such problems to DHP.

Observation 16 (p. 30)

The complaint classification schemes for quality of care concerns in Medallion II and in commercial oversight are dissimilar.

Observation 17 (p. 32)

The State Employee Health Benefits program handles complaints for state employees enrolled in HMOs. However, their valuable data on complaints would be lost if SEHBP did not work collaboratively with the BOI, VDH, DHP, and DMAS to adopt screening criteria, and to record and track the complaint according to the screening criteria in this report.

V. OPTIONS FOR THE STATE HEALTH COMMISSIONER TO CONSIDER

1. State Action Benefits Only a Relatively Small Percentage of Insured Virginians.

The Joint Commission on Health Care (JCHC) has reported that many of the Commonwealth's health insurance laws and regulations affect only about 25% of Virginians, approximately 19% in commercial group insurance and 6% with individual coverage (JCHC, 1996). This is due to the preemption of state law for self-funded plans through ERISA, and to the major role of the federal government in oversight of publicly funded programs. The JCHC estimates that, in 1992, 35% of Virginians were in ERISA plans. Comparable proportions for publicly funded plans were Medicare (12%), Medicaid (6%), and CHAMPUS (7%). At that time, it was estimated that 15% of the Virginia population was uninsured.

As discussed earlier in this paper, authority to regulate enrollee complaint systems and quality of care, as granted in Title 38.2, Chapter 43 of the *Code of Virginia*, applies to HMOs only. The Virginia Association of Health Maintenance Organizations (VAHMO) reports that enrollment in HMOs stood at nearly 1.38 million enrollees as of December 1996 (VAHMO, 1997), and included approximately 129,000 Medicaid recipients enrolled in Options and Medallion II. Thus, the commercially insured HMO population represents a substantial proportion of the 25% of Virginians protected by existing state health insurance laws and regulations.[30]

Standards for UR and appeals of final adverse UR decisions, as established in Title 38.2, Chapter 54, apply not only to HMOs, but to all managed care entities performing UR internally. It is probable that these laws and regulations affect a substantial proportion of the 25%, since traditional indemnity insurance is becoming less and less common, and all managed care entities, by definition, perform UR to some extent.

The *need* for an ombudsman or external appeal process may also be dependent upon the payer. For state employees, the DPT provides assistance and advocacy, and offers an administrative appeals process as well. Large employers, by virtue of their purchasing power, might be able to use persuasion very effectively in advocating for an enrollee, the implication being that there would be less of a need for an ombudsman or external appeals process. However, it may not be in the employer's best interest to support employees' benefit claims, especially if the employer is self-insured or experience-rated, which most large employers are. Commercially insured enrollees employed by smaller companies may fare no better. That is, not only could small employers' interests deter employee advocacy, but their lack of negotiating strength could limit the assistance they could offer. On the other hand, small employers who participate in purchasing cooperatives might have more negotiating strength, thus mitigating this situation somewhat. Finally, persons insured individually would not have an employer as a potential source of assistance with grievances.

ERISA self-insured employers may offer education and assistance services to their beneficiaries, and are required to uphold certain fiduciary responsibilities in their reviews of beneficiary grievances. Yet, as already discussed, DOL does not provide the level of individual complaint investigation typically provided by state insurance regulators. States, including Virginia, have become increasingly concerned that the limited grievance protections under ERISA will only become more problematic as more employers self-insure.[31] These concerns are evidenced in a National Governors' Association (NGA) report which calls upon the federal government to address these inequities. Two options are proposed by the NGA to address these inequities:

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[30]Some employer-based plans are moving into risk-sharing when contracting with HMOs, and as a result, are ERISA self-insured plans. A 1996 KPMG survey of employers with 200 or more employees reported that 20% of members were enrolled in fully or partly self-insured HMO plans (KPMG, 1997). This was up from 13% in 1995. In 1989, a Foster-Higgins survey found that only 4% of HMO plans were self-funded.

[31]States are also concerned about the growing number of smaller employers who self-insure and purchase stop-loss coverage. By purchasing stop-loss coverage, sometimes at a very low threshold, these employers bear only a portion of the risk, and are able to avoid state regulation with regard to health insurance. Court cases on states' ability to regulate them have been mixed.

- Congress should work with the states to establish national health care standards for self-funded plans that are similar to those imposed by states on commercial plans. If Congress is unwilling to define legislative standards in ERISA, the U.S. Department of Labor, in conjunction with the states, should be given the authority to develop regulations that, at the very least, establish essential consumer protections and remedies standards for self-funded plans.

- Anecdotal evidence suggests that consumer protections problems are more likely to arise in small self-funded plans. Congress could limit self-funding authority to businesses above a certain size. Businesses below that limit would be required to follow state laws. The U.S. Department of Labor would need to enforce standards for those plans that remain under its jurisdiction. (NGA, 1997)

Should such options be implemented, they would affect the number of Virginia residents eligible for state-initiated protections.

As discussed previously, Virginia's Medicaid population enrolled in Options, Medallion I and Medallion II managed care programs are afforded processes for dispute resolution through DMAS. Likewise, Medicare beneficiaries are afforded similar protections by the U.S. Health Care Financing Administration. In addition, the protections available to the commercially insured population through BOI, VDH and DHP are also available to Medicare and Medicaid beneficiaries.

2. The Main Point of Entry into the State System is BOI. However, There Are Other Access Points, Which May Create Confusion for the Consumer (Observation 2).

The main entry point for consumers with inquiries and/or complaints relating to their managed care plans is through BOI's toll-free phone number. Yet, consumers may also enter the state system through other agencies, and may find the system difficult to navigate if coordination among agencies is lacking. Moreover, if an agency's complaint protocols are dissimilar from others, and/or do not include coordination with other agencies, a consumer might obtain different results, depending on the agency consulted and the enforcement authority available to it. For example, a consumer in an ERISA plan who contacts BOI will be referred to the DOL, but would not necessarily be referred to the DOL if initial access was through another agency. To address this issue, collaboration between BOI and other state agencies could be explored to insure that ERISA complaints received by other agencies are identified and forwarded to BOI.

The Center's formalized process for coordinating complaints with BOI has been completed, and is provided in Attachment II as an example of complaint coordination.

3. Members and Subscribers in Other Managed Care Plans Do Not Enjoy the Same Level of Consumer Protections as Those Enrolled in HMOs (Observations 2 and 4).

PPOs and other non-HMO managed care plans are regulated as insurance plans. The protections of Chapter 54 apply to these entities, and to all forms of health insurance, if they perform UR internally. However, unlike HMOs, PPOs and other non-HMO managed care plans have no statutory or regulatory requirements for a grievance system, nor does VDH have any authority to investigate the quality of care complaints of subscribers and enrollees in these plans.

For managed care organizations that have incentives to use networks, more oversight than is currently provided by statute and regulation may be needed. In order to do this, "managed care plans other than HMOs" must first be defined.

BOI is currently studying additional regulation of managed care health insurance plans (SJR 611) and whether the quality and consumer protections contained in Chapter 43 of the *Code* should apply to those entities. Therefore, HB 2785 judgements about regulating other managed plans need to be coordinated with the study findings of SJR 611.

Virginians in ERISA plans also do not enjoy the same level of protections as those enrolled in HMOs. For these consumers, BOI could consider recording the number and nature of incoming complaint calls relating to ERISA plans, with the intent of pursuing an agreement similar to the Oklahoma/DOL partnership on ERISA complaint investigation. While the DOL does not currently have plans to include other states in pilot programs, this policy could change, especially if the Oklahoma demonstration is successful. Data on ERISA complaint calls received by BOI would provide supporting documentation, should there be future interest in Virginia cooperating with DOL on a similar project. In the meantime, BOI could consider communicating with the Assistant Secretary of the Pension Welfare Benefits Administration to express Virginia's interest in participating in future opportunities.

4. Consumers Would Benefit from a More Uniform Complaint/Grievance System Based on a Common Set of Key Concepts (Observations 3, 10, 16, 17, and 18).

The state oversight system for complaints and grievances is complex. despite the potential benefits of VDH's involvement in quality of care oversight for consumers, VDH's entry into the existing oversight structure will not completely eliminate confusion among consumers seeking complaint remedies. However, there are steps that the state can initiate at the system level to reduce confusion and to benefit consumers in general. First, all state agencies involved in consumer oversight of complaints relating to the care delivered in managed care organizations, including HMOs, could adopt a common set of terms central to the complaint/grievance systems. For example, both the commercial and Medicaid complaint/grievance systems could use the same terms and definitions of the key concepts. This report suggests that 'inquiry,' 'complaint,' and 'grievance,' be defined in statute so that regulatory agencies can write them into their formal guidance including regulations and contracts. The adoption of 'inquiry' recognizes the principle that MCOs should be given opportunity to resolve disputes about their own plans and to assist their members in seeking mutually satisfactory solutions before requesting government

The Pennsylvania Department of Health publishes HMO grievance system operational standards which include the following definitions:

Inquiry: An inquiry is any member's request for administrative service, or information, or to express an opinion. Whenever specific corrective action is requested by the member, or determined to be necessary by the HMO, it should be classified as a complaint.

Complaint: A complaint is an issue a member presents to the HMO, either in written or oral form, which is subject to informal resolution by the HMO within a thirty-day period. All HMOs must establish and maintain an effective complaint resolution system, including a written log of each complaint and its disposition. Failure to render a decision within the thirty-day time frame automatically results in the complaint being upgraded to a grievance.

Grievance: A grievance is a complaint which cannot be resolved to the member's satisfaction or when the member requires formal grievance consideration during the thirty-day period. All grievances shall be committed to written form either by the member or the HMO prior to processing.

Source: Pennsylvania Department of Health, *HMO Grievance Systems: Operational Standards for Fundamental Fairness for HMO Members*, August, 1991.

intervention. 'Complaint,' and 'grievance' are defined by the level of formality, point in the process, and cause for remedy. Definitions similar to those used by Pennsylvania, which are shown in the nearby text box, could be codified.

A second step that the state could take involves a uniform classification of quality of care complaints. The state agencies responsible for oversight of managed care plans could adopt a single scheme to screen quality of care complaints. BOI, VDH, and DMAS, as well as DPT, could continue to collaboratively develop more uniform classifications of complaints, both to simplify the system for consumers and to permit comparison and analysis across plans.

The screening criteria developed by the Center (Attachment I) provide an example of complaint classification. The three main classifications are "access to health care services," "utilization management," and "provider/practitioner concerns and issues." Several agencies have indicated that greater coordination and collaboration in this area would benefit consumers. The combination of the common terms and classifications across state agencies will help consumers and policy makers to observe the types of problems that Virginians are having with their health plans.

The public would also benefit from a tracking report, which could be generated from the annual complaint report submitted by all HMOs. Complaints and grievances could be followed and become part of a public record that the State Health Commissioner submits to the Commissioner of Insurance annually. A tracking report, and therefore, HMOs' annual complaint reports, would require 'key concept' definitions and standardized complaint classifications to be informative. A requirement for HMOs to use standardized complaint classifications in their annual reports would not require legislation, since Section 38.2-4308(B) states that HMOs must submit an annual complaint report "in a form prescribed by the (State Corporation) Commission, after consultation with the State Health Commissioner."

5. The VDH Could Assume New and Increased Responsibility for Educating Consumers and Facilitating the Resolution of Their Complaints (Observations 1, 13, and 14). In the past, the previously named Office of Health Facilities Regulation (OHFR) provided education and training opportunities for facility staff. However, during the transitional period since OHFR was renamed as the Center for Quality Health Care Services and Consumer Protection, it has been trying to adapt its mission to include education for consumers enrolled in HMOs. The Center's complaint resolution experience to date demonstrates that consumers are seeking education and information about their plan rights and responsibilities, in addition to other complaint assistance. The shift toward consumer education is viewed as a modified ombudsman role. The Center is finding that these consumers are enrolled in all types of managed care plans, not just in the plans (HMOs) for which the Center currently has oversight authority.

Public policy related to this new role should not supplant the customer service and grievance functions that are available to consumers through their plans, and that are the responsibility of the managed care plans. Nor does the Center wish to take over functions, such as submitting the complaint to the HMO's internal grievance system, which should remain the responsibility of the "fair-minded consumer." Instead, the Center could be part of a larger effort, in conjunction with other state agencies and private entities, to provide education and information to consumers regarding their health plans. In this

role, the Center would be available to advise an enrollee of his rights, to provide information about how state law may apply to the enrollee's situation, and to encourage the enrollee to reconnect with the plan's internal grievance system. In addition, the state would ensure that it has additional resources to handle inquiries and complaints not just from HMO enrollees, but for consumers of other forms of managed care as well.

As discussed earlier in this document, the functions of the Educator/Facilitator could be explicitly considered in determining the staffing needs for quality oversight. A determination of the full-time equivalents needed for these responsibilities could be made, and a budgetary amendment developed for funding them. If VDH oversight expands to other forms of managed care, the new responsibility should not be funded solely by HMOs through their examination fees. Instead, there could be a mechanism, such as a certification process, through which other forms of managed care entities would support these functions.

6. Grievance Protections for Utilization Review Denials Could be Coordinated with Chapter 43, and Could Include the Covered Person in all Levels of Appeal (Observations 5, 6, and 7).

Both the grievance system prescribed by statutes (Chapter 43) and regulations, and the appeal process prescribed by Chapter 54, could be coordinated to more adequately protect consumers who wish to grieve utilization review decisions. Complaint system regulations do not provide for a timely response from the HMO or for review by a peer of the treating provider. The language of Chapter 54 is confusing on certain points. It does not appear to permit a consumer to initiate a request for reconsideration (Section 38.2-5406(A)), or to require that HMOs share UR criteria with consumers, only with providers (Section 38.2-5402(A)). In order to address these issues, consideration could be given to amending statutes and regulations addressing HMO grievance systems in order that they contain the identical requirements for UR grievances as are found in Chapter 54, such as the response time from HMOs in responding to grievances concerning UR decisions. In addition, consideration could be given to amending Chapter 54 to clarify that it includes "covered person," so that it is explicit that an HMO member can initiate a reconsideration of an adverse decision, and have access to the UR criteria pertinent to his case, without the intervention of the treating provider. Finally, an amendment to Chapter 54 could also specify that UR appeal rights be included alongside the grievance system description in the evidence of coverage issued by the HMO.

Utilization review appeals, so central to the quality "feedback loop," can be made more effective tools for finding mutually satisfactory solutions in disputes between the enrollee and the UR entity. The collection and compilation of a sample of UR data would provide important information regarding the implementation of Chapter 54. Annual submission and review of utilization review records would provide important system-level consumer information. Since the Bureau of Insurance has no authority to adjudicate controversies arising out of Chapter 54, nor does it report having the clinical expertise to evaluate the appropriateness of UR denials, it is appropriate for VDH to assume statutory responsibility for oversight and administration of Chapter 54, and for the Health Commissioner to establish a method for evaluating compliance with Chapter 54. With regard to Chapter 53, DHP's interest is very narrow. Therefore, it may not be appropriate to transfer oversight and administration of Chapter 53 to DHP.

7. The Enforcement of Sanctions Resulting from Violations of Law Will Continue to Be the Focus of State Oversight. However, VDH Would Need New Authority to Discharge its Statutory Mandate (Observations 8, 9, 11, 12,).

It is important to emphasize that the HMO statutes and regulations provide for HMO grievance and quality *systems*. Enforcement by regulatory agencies ensures that the systems are in place for appropriate grievance and quality protections.

BOI has broad authority to enforce provisions of Title 38.2 of the *Code of Virginia* under which all insurance statutes are included. The primary source of BOI's enforcement authority is found in Section 38.2-218 through Section 38.2-221. Among other penalties, the Bureau, through the State Corporation Commission, is authorized to:

impose a penalty of up to $5,000 for each knowing or willful violation of any provision of Title 38.2 or any regulation issued by the SCC pursuant to Title 38.2;

impose a penalty of up to $1,000 for each violation of Title 38.2 or any regulation issued by the SCC pursuant to Title 38.2 committed without knowledge or intent. For a series of related violations resulting from the same act, the penalty is capped at $10,000;

require the payment of restitution under certain named circumstances;

issue cease and desist orders, temporary injunctions and permanent injunctions, and may impose monetary penalties of up to $1,000 per day for violations of such cease and desist orders and injunctions (Sec. 12.1-33). In addition, the SCC has the authority to enforce its injunctions by civil penalty or imprisonment;

suspend or revoke the authority of an insurer or HMO to transact business in the Commonwealth.

The role of the State Health Commissioner lacks actual enforcement authority; rather, " an HMO license may be suspended or revoked by BOI upon the State Health Commissioner's certification to the [State Corporation] Commission that an HMO cannot furnish quality health services consistent with prevailing medical standards and practices." (Section 38.2-4316(A)(4)) This certification authority is limited only to the State Health Commissioner's verified reports to the State Corporation Commission with respect to the systemic inability of an HMO generally to furnish services that fail to meet professional standards for quality of care. Such certification does not apply directly to the HMO licensee. The governing statute does not address individual consumer grievances and appeals for purposes of the State Health Commissioner's review. Further, there is no current authority for the State Health Commissioner to certify that an HMO *can* furnish quality health services. Even under the new mandate effective July 1, 1997, there is no authorized process for certification of HMOs for recognized quality of care. Thus, consideration could be given to enabling legislation that would authorize the State Health Commissioner to establish a certification process (as contrasted with the licensing process performed by BOI) under which HMOs would submit to quality of care review culminating in a certification from VDH. This certification process could be renewable and reviewable at some established interval, affording VDH the opportunity to review the HMO's quality of care on a regular basis. The sanction for an HMO's failure to adhere to VDH's standards for quality of care, then, could be loss of certification, and, if the General Assembly so determined, monetary penalties, with the licensee's right of appeal to BOI from recommendations to BOI. Only in the event that the State Health Commissioner became convinced that a

particular HMO's general services were systematically and sufficiently egregious to justify license termination would the State Health Commissioner certify such a recommendation to BOI.

HB 2785 requires the State Health Commissioner to "examine the quality of health care services of any health maintenance organization" as well as to examine the complaint system of HMOs. The new statute does not, however, provide authority for the State Health Commissioner or the Board of Health to set standards to be met by HMOs with regard to the quality of health care provided by HMOs, or the standards which should be met by the enrollee grievance system with regard to quality of care. Additionally, the State Health Commissioner is not granted the authority under current statutes to enforce sanctions for non-compliance with quality of care standards, short of reporting to the State Corporation Commission that an HMO is unable to furnish quality health care and should have its license revoked as provided in Section 38.2-4316(A)(4) of the *Code of Virginia*. In short, the State Health Commissioner lacks enforcement authority. A regulatory scheme permitting the State Health Commissioner to impose more reasonable sanctions for violations of activities regulated by VDH might be more appropriate.

The State Health Commissioner could consider proposing legislation that would authorize the Board of Health or the Commissioner to issue certificates of HMO compliance with grievance and quality standards. Further, such legislation would authorize the Board of Health to develop and promulgate regulations to establish procedures of review, standards for review of grievance systems, and mechanisms for enforcement based upon severity and scope of noncompliance. Such new legislation would relieve BOI of its responsibility to enforce findings of a sister agency by sanctions of its licensees. The Commissioner would continue to report certification activities to the BOI as licensing agency.

8. Enforcement for Individual Complaints Involving Quality of Care Is Problematic.

Review of specific individual quality of care complaints has not been legislatively established. Section 38.2-4316.A(4) of the *Code of Virginia* defines quality health services as those that are "consistent with prevailing medical standards and practices." Under section 38.2-4308 of the *Code* and the interim Memorandum of Agreement executed in late 1996, BOI refers quality of care complaints to the State Health Commissioner, but such complaints are limited to those that implicate an HMO's complaint system. The authority for the State Health Commissioner to conduct examinations in response to individual complaints is not conferred under section 32.1-122.10.01 of the *Code*, which assures only that the State Health Commissioner shall examine the quality of health care services of any licensed HMO "as often as considered necessary for the protection of the people of this Commonwealth." Arguably, under this authority, and that of the interim Memorandum of Agreement, the State Health Commissioner may investigate individual cases and find that a particular consumer's complaint appears to have merit. The State Health Commissioner may provide that analysis with expert discretionary findings; however, the State Health Commissioner has no sanction authority. The State Health Commissioner can only advise BOI of its findings. The SCC's sanction authority is limited to violations of Title 38.2 and regulations issued pursuant to Title 38.2. An individual instance in which the State Health Commissioner reports that the HMO apparently failed to provide quality health care to an individual complainant is not sufficient under the insurance laws for the SCC to initiate an action.

Individual complaints on quality concerns, even when possibly meritorious on analytical review and reported by the State Health Commissioner, are not sanctionable by the State Health Commissioner, BOI or any other regulatory agency. Thus, an important function of this analysis is to identify and engage such reviews and reports into some process that does not implicate such analytical reviews and reports in any future individual process. As stated in section 38.2-4319(C) of the *Code*, an HMO "...shall not be deemed to be engaged in the unlawful practice of medicine"; thus, while an individual complaint investigation, on review, may report that the HMO has not provided care in accordance with prevailing standards and practices, at the present time sanction authority is absent unless the practice is systemic and leads to State Health Commissioner certification to suggest BOI imposition of suspension or revocation of licensure.

It is important to emphasize that providing remedies to individuals who appear to have meritorious grievances is not the role of regulatory agencies. Individual complaints reside in the courts. This is not to say that BOI and VDH may not assist in the relief when an individual's grievance has been investigated and, on analysis, appears founded. BOI's staff will make numerous efforts to convince the insurer or HMO to modify or retreat from its position, and, in many cases, such efforts are successful. Further, when a practice discovered during the handling of a complaint can be determined to be a violation of the insurance laws or regulations, BOI can and does initiate disciplinary proceedings against the insurer or HMO. Such proceedings may result in a settlement, one component of which may be to provide the resolution sought by the individual complainant. In fact, such settlements may result in relief for other similarly situated individuals who may not have filed a complaint. However, BOI's role is not one of adjudicating individual complaints, nor does BOI (or VDH) have the authority to do so.

Similarly, upon investigation and analysis of an individual's complaint about a hospital or nursing facility, VDH may find that the complaint appears founded. The individual will receive a copy of VDH's report on the investigation, but VDH has no authority to require the facility to provide a remedy to compensate the individual for the wrongful act or omission. The individual must pursue a remedy or damages in civil court.

It must be stressed again that BOI has no authority to adjudicate controversies arising out of Chapter 54 of Title 38.2, which governs utilization review appeals. There is general agreement that the majority of utilization review appeals arise from disputes of a medical nature. BOI does not have jurisdiction to adjudicate contract disputes. In this regard, 14 VAC 210-140 states, "The Commission shall have no jurisdiction to adjudicate controversies between a health maintenance organization and its enrollees, and a breach of contract shall not be deemed a violation of this chapter."

Thus, while BOI and VDH may investigate complaints, and BOI can enforce the provisions of Title 38.2 and the regulations issued pursuant to Title 38.2, these regulatory agencies do not have the authority to require that an HMO provide relief to the individual with an apparently valid grievance concerning quality of care. Individuals would seek such relief in court. However, under Virginia law, a claimant cannot seek punitive damages (Section 38.2-4319(C)).

9. Consumers Would Benefit From Improved Reporting of Disciplinary Actions Against Network Physicians (Observation 15).

Consideration could be given to including HMOs and other managed care organizations in the statutory language of Section 54.1-2906, which currently sets forth the requirements for hospitals and other institutions to report certain disciplinary actions and medical conditions to DHP.

ATTACHMENT I

SCREENING CRITERIA FOR COMPLAINTS THAT MAY ADDRESS QUALITY OF CARE ISSUES
Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection

The VDH will investigate complaints where the quality of the health care services provided to enrollees by a health maintenance organization (HMO) licensed in Virginia, or one of its contractors, is in question. The quality of health care services provided by an HMO will be reviewed within the context of the enrollee's health plan coverage, mandated benefits, and the laws and regulations governing the provision of health care services provided by the health maintenance organizations and their providers contained within the *Code of Virginia*, 1950, as amended, and the *Virginia Administrative Code*.

Complaints concerning the quality of health care services can generally be applied to the categories that are listed below.

ACCESS TO HEALTH CARE SERVICES

- Geographic access limitations to providers and practitioners
- Availability of PCPs, specialists, behavioral and mental health providers
- PCP after-hour access
- Access to urgent care and emergency care
- Out-of-network access
- Availability and timeliness of provider appointments and provision of services
- Availability of outpatient services within the network (to include HHA, hospice, labs, physical therapy, radiation therapy)
- Enrollee provisions to allow transfers to other PCPs
- Patient abandonment by PCP
- Pharmaceuticals (based on patient's condition, use of generic drugs versus brand name drugs)
- Access to preventative care (immunizations, prenatal, STDs, alcohol, cancer, coronary, smoking)
- Access to HMO complaint and grievance procedures
- HMO enrollee notification regarding changes in the EVIDENCE OF COVERAGE and mandated benefits

UTILIZATION MANAGEMENT

- Denial of medically appropriate services covered within the enrollee contract
- Limitations on hospital length of stays for stays covered within the enrollee contract
- Timeliness of preauthorization reviews based on urgency
- Inappropriate setting for care i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
- Criteria for experimental care
- Unnecessary tests or lack of appropriate diagnostic tests
- Denial of specialist referrals allowed within the contract
- Denial of emergency room care allowed within the contract
- Failure to adequately document and make available to the members reasons for denial
- Unexplained death
- Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to progress to a more severe form
- Organ transplant criteria questioned

PRACTITIONERS/PROVIDERS

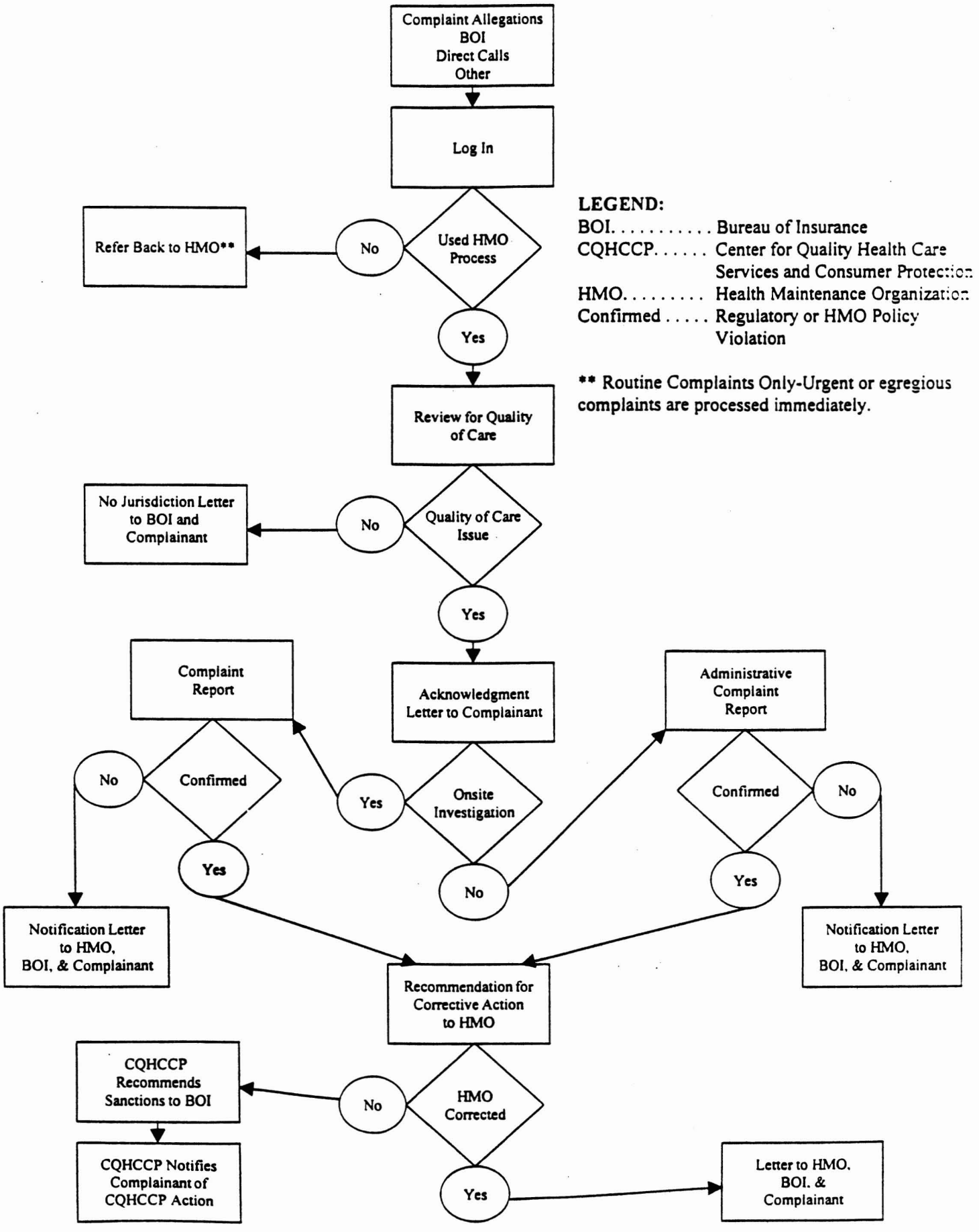
- Appropriateness of diagnosis and/or care
- Appropriateness of credentials to treat
- Failure to observe professional standards of care, state and/or federal regulations governing health care quality
- Unsanitary physical environment
- Failure to observe sterile techniques or universal precautions

•Medical records - Failure to keep accurate and legible records, to keep them confidential and to allow patient access
•Failure to coordinate care (Example: appropriate discharge planning)

The Center's expectation would be that HMO members had attempted to resolve their complaints initially by accessing the HMOs internal complaint resolution process and/or their employers' health benefits office prior to bringing their complaints to the Center unless the complaint was so urgent that it placed the patient or others in serious jeopardy.

Attachment II

The Center for Quality Health Care Services and Consumer Protection's HMO COMPLAINT PROCESS



LEGEND:

BOI. . . . . Bureau of Insurance
CQHCCP. . . . . Center for Quality Health Care Services and Consumer Protection
HMO. . . . . Health Maintenance Organization
Confirmed . . . . . Regulatory or HMO Policy Violation

** Routine Complaints Only-Urgent or egregious complaints are processed immediately.

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APPENDIX I

STATE LAWS AND REGULATIONS PROVIDING QUALITY AND GRIEVANCE PROTECTIONS

assess the quality of health care services provided." This regulation is identical to Section **§38.2-4301.B.11.** of the *Code*.

b. All Health Insurers

There are no laws or regulations pertaining explicitly to quality for other forms of managed care. A quality program is not required and there are no provisions for examination of the quality of health services by the Health Commissioner.

2. Complaint Resolution and Consumer Satisfaction

a. HMOs Only

***Code of Virginia* §38.2-4308., HMOs required to have a complaint system**

This section requires that HMOs establish a complaint system for the resolution of written complaints. The complaint system must be approved by the State Health Commissioner and the Bureau of Insurance. This section also requires that HMOs submit to the Health Commissioner a copy of their annual complaint report. Both the State Corporation Commission (the Bureau of Insurance) and the State Health Commissioner are required to examine HMO complaint systems although the SCC may accept the Health Commissioner's report rather than conduct their own examination.

Virginia Administrative Code, 14-5-210-70.H., Grievance Procedure

This regulation expands on the *Code* requirement at 38.2-4308, stipulating that records of all complaints be maintained for three years and requiring that HMOs provide complaint forms and/or written procedures to enrollees. Grievances are required to be resolved in not more than 180 days. This regulation also prohibits termination of a member's coverage for any reason related to the grievance and makes provisions that apply in the event of specific arbitration agreements.

***Code of Virginia*, §38.2-4318, Suspension or Revocation of Licensure**

This section expressly provides for loss of licensure if the HMO fails to implement a complaint system in accordance with 38.2-4308.

b. All Health Insurers

***Code of Virginia*, §38.2-511, Requiring Records of Complaints**

There are no statutes or regulations requiring that health insurers other than HMOs have

grievance systems or procedures. The Code section cited above requires all insurance companies to maintain complete records of all complaints since the last market conduct examination or for the last three years, whichever is the more recent time period. This section also defines a "complaint" as any written communication expressing a grievance.

***Code of Virginia*, Chapter 54 of Title 38.2, Appeals of Utilization Review Decisions**

Chapter 54 applies to all health insurers that perform utilization review (UR), the determination of whether covered services are medically necessary. Chapter 54 provides for appeals of UR decisions, and thus addresses one of the most important aspects of consumer protections in managed care. Chapter 54 contains the following provisions:

- Health Insurers are required to establish standards and criteria to be applied in UR decisions. These standards are required to be reviewed by appropriate board-certified physicians; to be compatible with "established principles of health care," and sufficiently flexible to permit needed exceptions. This section also requires the insurer to make available to providers, on written request, the UR standards and criteria and the list of physician advisors and their areas of specialty. (§38.2-5402.A)

- UR staff are required to be properly qualified and supported by a physician advisor, and a representative who is authorized to approve UR decisions must be available to providers and covered persons. (§38.2-5402.E)

- Health Insurers are required to notify covered persons of the review process, and to also notify providers upon written request. (§38.2-5402.F)

- Health Insurers are required to communicate UR decisions no later than two business days after receipt of all necessary information.(§38.2-5402.G)

- Health Insurers are required to have a utilization review plan that contains procedures for compliance with Chapter 54. The plan must contain specific procedures to be used in UR determinations; provisions for advance notice to enrollees of any requirements for pre-authorization of services; and provisions for reconsiderations and appeals of UR decisions. This section requires the insurer to make available to providers and enrollees, on written request, a copy of those portions of the UR plan that are relevant to the specific request. (§38.2-5403)

- The first denial by the insurer of a covered service is called an adverse decision and must be communicated to the treating provider within two business days. The provider must be notified at this time of the instructions for requesting a reconsideration of the adverse decision. (§38.2-5406) If the reconsideration is to again deny coverage for the service, it is called a final adverse decision and must include the criteria used and the clinical reason

for the adverse decision as well as alternate treatments. Reconsiderations must be completed within ten business days, and providers must be notified of the opportunity for an appeal of the final adverse decision. (§38.2-5407)

- Every health insurer is required to have a process for appeals of final adverse decisions that are appealed by covered persons, their representative, or their provider. Response to appeals must be provided to appellants no later than sixty business days after the insurer has received all required documentation. The appellant may request that the decision on the appeal be in writing and all decisions must state the criteria used and the clinical reason for the decision. (§38.2-5408.A.)

- Reconsiderations and appeals must be reviewed by a provider advisor or advisors, at least one of whom is a peer of the treating health care provider. The peer provider must be specialized in the same or similar discipline as the treating health care provider, and, if a physician, must be board certified or board eligible. The peer provider may not have participated in any previous decisions regarding the case under appeal; must not be employed by or a director of the insurance company, and must be licensed to practice in Virginia or a state with comparable licensing laws. (§38.2-5408.B.)

- Appeals of adverse decisions or adverse reconsiderations may be made on an expedited basis if the time limits for regular reconsiderations and appeals would create a delay that would be detrimental to the health of the covered person. (§38.2-5408.E.2.) The requirements for peer review at §38.2-5408.B. do not pertain to expedited decisions.

- Health insurers are prohibited from terminating provider contracts or penalizing providers for advocating for patients in the appeals process unless the provider "engages in a pattern of filing appeals that are without merit." (§38.2-5408.G.)

- All insurers subject to Chapter 54 are required to maintain in writing records of review procedures; qualifications of UR staff; UR criteria; all appeals and the manner in which they were resolved; the number, type and outcome of adverse decisions and appeals; expedited appeals; and procedures for ensuring confidentiality of medical records. Records must be maintained for a period of five years, and all records are subject to examination by the State Corporation Commission. (§38.2-5409)

3. Access and Availability

a. HMOs Only

***Code of Virginia*, §38.2-4301.4**
***Virginia Administrative Code*, 14 VAC-5-210-50.B.3.e.**
***Virginia Administrative Code*, 14 VAC-5-210-110.C.**
This statute and these regulations require an HMO to file with the Bureau of Insurance either every contract they have with a provider, or every type of contract and a list of providers in their networks. This is a condition for licensure and enables the Bureau to assess the accessibility, and to some degree, the adequacy of the network. The *Code* further requires that the list of providers with whom the HMO has contracts be updated quarterly and filed with the Bureau. (§38.2-4311)

***Virginia Administrative Code*, 14 VAC-5-210-90.A., Access to Care**

This regulation provides the following standards for access to care:

1. Each health maintenance organization shall establish and maintain adequate arrangements to assure both availability and accessibility of adequate personnel and facilities providing health care services including:

a. Reasonable hours of operation and after-hours emergency health care;

b. Reasonable proximity to enrollees within the service area so as not to result in unreasonable barriers to accessibility;

c. Sufficient personnel, including health professionals, administrators, and support staff, to reasonably assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees; and

d. Adequate arrangements to provide inpatient hospital services for basic health care.

2. Each health maintenance organization shall make available to each enrollee the services of specialists as part of the provision of basic health care services. "

***Code of Virginia*, §38.2-4300, Definition of Emergency Services**:

This section defines emergency services as care sought in response to the sudden onset of symptoms of sufficient severity that a prudent layperson could reasonably expect to result in serious impairment to physical or mental health. This definition is an important protection for HMO members because it defines an emergency on a prospective basis from the consumer's viewpoint rather than on a retrospective basis from the HMO's viewpoint.

***Code of Virginia*, §38.2-4312.3.A., Patient Access to Emergency Services**

This section requires HMOs to provide 24-hour access to medical care or by telephone to a licensed health care professional who can refer an HMO member to appropriate care.

***Code of Virginia*, §38.2-4312.3.B., Reimbursement for Emergency Services**
This section reinforces the previous provisions for emergency care with the requirement that an HMO cover any emergency services for which the patient was referred by a physician or other person acting as an agent for the HMO. It also requires HMOs to cover any emergency room payment if the HMO fails to have a system for provision of twenty-four-hour access.

***Code of Virginia*, §38.2-4312.1, Pharmacies; Freedom of Choice**

This section permits an HMO enrollee to select any out-of-network pharmacy from which to receive pharmacy benefits as long as the pharmacy has notified the HMO in advance that it will accept reimbursement commensurate with the HMO's contracted rate.

b. All Health Insurers

***Code of Virginia*, §38.2-3407.10.J and K, Contracts may not prohibit discussion of treatment options, contracts must require discussion of treatment options**

This section of the code requires any insurers contracting with providers to ensure that provider contracts do not prohibit the provider from discussion of treatment options with patients. Section K requires that contracts "permit and require the provider to discuss medical treatment options with the patient."

***Code of Virginia*, §38.2-3407.10.C., and §38.2-3407.10.F.1. Continuity of Care**

This first section of the *Code* provides for notification to enrollees when their primary care provider's contract is terminated by an insurance carrier and establishes the right of an enrollee to continue receiving services for sixty days from the date of the primary care physician's notice of termination. 38.2-3407.10.10.F.1. provides for continuity of care for at least sixty days with any contracted provider from the date of notice of termination when the patient has been in an active course of treatment with the provider and desires to continue treatment.

***Code of Virginia*, §38.2-3407.11, Access to Obstetricians and Gynecologists**

§38.2-3407.11 permits covered females thirteen and older to self-refer directly to Obstetrician/Gynecologists without a referral or authorization from the primary care physician or the insurance plan. This section requires that the insurer notify its subscribers of this provision.

***Code of Virginia*, §38.2-3414.1, Maternity Length of Stay**

Mandates post-partum services in accordance with specific guidelines of the American Academy of Obstetricians and Gynecologists and the American Academy of Pediatrics. This section ensures an appropriate length of stay in the hospital following delivery and provides for home health services following a stay shorter than 48 hours for a normal delivery or 96 hours for a Caesarean Section delivery.

***Code of Virginia*, 38.2-3407.7, Pharmacies, Freedom of Choice**

This section permits enrollees to select any pharmacy to provide covered pharmacy benefits whether or not the pharmacy is contracted by the insurance plan, and makes provisions for non-contracted pharmacies.

***Code of Virginia*, 38.2-3407.6, Inclusion of Podiatrists**

Health Insurers are prohibited from excluding podiatrists solely for the reason that the insurer requires contracted providers to have hospital privileges as long as the podiatrist is able to perform the type of services that are covered by the insurance plan.

***Code of Virginia*, 38.2-3407, Any Willing Provider**
(APPLIES TO PPO'S ONLY)

This section requires Preferred Provider Organizations (PPO) to include in their provider networks any hospital, physician or type of provider listed in §38.2-3408 willing to meet the terms and conditions offered by the PPO.

4. Prevention

a. HMOs only

***Code of Virginia*, §38.2-4300, definition of health care services for HMOs**
***Virginia Administrative Code*, 14 VAC 5-210-90, HMO Services**

§38.2-4300 defines "basic health care services" provided by HMOs to include "preventive health services". The regulation at **14 VAC 5-210-90.B.** specifies the minimum basic health services HMOs are obligated to provide and includes "[p]reventive health services: services provided with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability, including well-child care from birth, eye and ear examinations for children age 17 and under to determine the need for vision and hearing correction, periodic health evaluations, and immunizations..."

b. All Health Insurers

***Code of Virginia*, §38.2-3411.1, Coverage for Child Health Supervision Services**
***Code of Virginia*, §38.2-3418.1. Coverage for Mammograms**
***Code of Virginia*, §38.2-3418.1:2, Coverage for Pap Smears**
***Virginia Administrative Code*, 14 VAC 5-234-50, Essential Benefits Plan**

These sections of the Code require insurers, health services plans and health maintenance organizations to cover child health supervision services, mammograms, and pap smears. The regulation cited mandates that insurers offering Essential Benefit Plan contracts cover preventive care for children "consistent with the current recommendations of the American Academy of Pediatrics and for adults according to the recommendations of the American Academy of Family Physicians."

5. Credentialing

a. HMOs Only

***Code of Virginia*, §38.2-4300, Definition of HMO Provider**

Nothing in the insurance title of the Code of Virginia or in administrative law requires that HMOs examine the credentials of providers with whom they contract. HMOs are only required to contract with licensed providers as indicated in the definitions section at §38.2-4300 which defines provider as "any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services."

b. All Health Insurers

***Code of Virginia*, 54.1-2902, unlawful to practice medicine without a license**

This section of the Code makes it unlawful to practice medicine, osteopathic medicine, chiropractic, podiatry, physical therapy, clinical therapy etc. without a valid unrevoked license issued by the Board of Medicine.

***Code of Virginia*, 32.1-123 et seq., licensure of facilities**

These sections of the Code set out the requirements for licensure of facilities, including hospitals, nursing homes and home health agencies.

***Code of Virginia*, 32.1-134.1 through 32.1-134.4, hospital credentialing of providers**

This section of the Code addresses procedures and standards that hospitals must follow in granting staff membership or clinical privileges to providers.

***Code of Virginia*, 54.1-2906, mandate to report disciplinary actions against providers**

Sec. 54.1-2906 requires hospitals "and other health care institutions" to report disciplinary actions against health professionals to the Board of Health Professions; however, health maintenance organizations and other insurers are not included in the definition of health care institutions. Sec. 54.1-2906.B. requires the State Health Commissioner also to report to the appropriate board information of fraud or unethical or unprofessional conduct by a practitioner.

The Commonwealth's current authority for credentialing of providers rests with the requirements for licensure and renewal assumed by the Board of Health Professions and the Department of Health. This authority pertains to individual practitioners and facilities, not insurers.

6. Consumer/Provider Education and Awareness

a. HMOs Only

Obligations of the Insurer for disclosure are an important consumer protection. The following statutes and regulations require HMOs to disclose particular information to the consumer:

***Code of Virginia*, 38.2-4306, Evidence of Coverage notification requirements**

The Evidence of Coverage (EOC) is the insured's contract or agreement with an insurance company "issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled" (**Code, 38.2-4300,** definitions). **38.2-4306** requires that HMOs disclose to the consumer the following:

1. All health care services and benefits to which the enrollee is entitled
2. Any limitations on services and benefits, including copayments and deductibles
3. Where and how to receive information as to how services may be obtained
4. The total amount of out-of-pocket expenses the enrollee is obligated to pay
5. A description of the HMO's method for resolving enrollee complaints

6. A list of providers and a description of the service area, if such information is not given to the enrollee at the time of enrollment

7. The right of group contract enrollees to convert their coverage to an individual contract

The *Code* (**38.2-4312.3.C**). additionally requires that the EOC include a description of procedures to be followed in an emergency and the member's potential financial responsibility of payment for non-emergency services rendered in a hospital emergency room.

***Virginia Administrative Code*, 14 VAC 5-210-100, Disclosure Requirements**

The disclosure requirements necessary in the EOC are listed in this regulation and contain the same provisions as those in the *Code* at 38.2-4306 in virtually identical language. This regulation additionally contains requirements for disclosure of the terms of coverage and termination; provisions for coordination of benefits, assignment restrictions, and eligibility requirements; procedures for filing claims; and premium grace periods.

***Code of Virginia*, 38.2-4306.e.; 14 VAC-5-210-70.H.2, Disclosure of Grievance Procedures**

HMOs are required to disclose the enrollee grievance procedure in the Evidence of Coverage **(38.2-4306.e)**. The regulation cited requires the HMO to provide complaint forms and/or written procedures to enrollees who wish to file a written complaint. The information provided must include appropriate telephone numbers and addresses as well as time frames for grievances.

***Virginia Administrative Code*, 14VAC-5-210-70.D. and E., Description of Providers Annually or upon Request; Service Area Disclosure**

These regulations require that HMOs notify subscribers at the time of enrollment or the issuance of the EOC the names of all network providers and the HMO's service area. This information must also be available on written request of the enrollee or at least annually.

***Virginia Administrative Code*, 14 VAC-5-210-70-C., Notification of Maximum Copayment Amount**

This regulation requires an HMO to disclose the maximum copayment amount in the enrollee's EOC. Another provision requires the HMO to keep accurate records of each enrollee's copayment expenses and to notify the enrollee when the maximum is reached.

***Virginia Administrative Code*, 14 VAC-5-210-70.G., Freedom of Choice of Physician**
***Code of Virginia*, 38.2-4304.B.; *Virginia Administrative Code*, 14 VAC 5-210-50.B.3.o., Consumer Involvement Required**

Other statutes and regulations addressing consumer satisfaction for HMO enrollees include:

***Virginia Administrative Code*, 14 VAC-5-210-70.G.** which requires that an HMO allow an enrollee the right to select a primary care physician (PCP), subject to availability, and to change PCP's.

***Code of Virginia*, 38.2-4304.B.** requires the governing bodies of HMOs to establish a mechanism to provide enrollees with the opportunity to participate in "matters of policy and operation," either through the establishment of advisory panels, advisory referenda on major policy decisions, or some other mechanism. The associated regulation at **14 VAC-5-210-50.B.3.o.** requires as a condition for licensure a description of how the HMO will implement 38.2-4304.B. of the *Code*.

b. All Health Insurers

Disclosure requirements for other forms of health insurance are fewer than those for HMOs, as follows:

***Code of Virginia*, §38.2-305; Disclosure of Bureau of Insurance Toll-Free Number for Assistance**

This section requires all insurers to disclose in their contracts or policies information on how to contact the Bureau if they are unable to obtain satisfaction from their insurance company or agent. HMOs are additionally required to add the statement: "We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action." This section also requires disclosure of particulars of the insurance policy including premium, specific risks the subscriber is insured against, and the conditions pertaining to the insurance.

***Code of Virginia*, §38.2-5402.F Notification of review process**

All insurers that engage in utilization review (UR) activities are required to notify covered persons of the review process.

***Code of Virginia*, §38.2-3407.10.G.1., list of providers and who's not accepting new patients**

This section requires that any health insurance plan that establishes a panel of providers must notify purchasers at least annually of the list of providers on the panel and include an indication of providers not currently accepting new patients.

***Code of Virginia*, §38.2-3407.4. Notification to purchaser of plan of incentives**

Health insurers are required to provide purchasers with a description of all types of payment arrangements used to compensate providers including risk-based payment and incentives to control utilization of services.

7. Outcome Measures and Accountability

a. HMOs Only

There are no mandated outcome measures required of HMOs only.

b. All Health Insurers

***Code of Virginia*, §32.1-276.2 et seq.**

This section of the code specifically addresses outcome information by providing for the State Health Commissioner to contract with a non-profit organization to compile, store, analyze, and evaluate data submitted by health care providers. The definitions section, **32.1-276.3** defines "provider" to include "any person licensed to furnish health care policies or plans..." and so would include all health insurance carriers. **32.1-276.4** requires the Board of the non-profit entity to disseminate health care cost and quality information designed to assist consumers in purchasing health care services, including HEDIS information or reports voluntarily submitted by HMOs. (HEDIS is the acronym for Health Employer Data and Information Set, a set of outcome measures developed by the National Committee for Quality Assurance.) This section also requires that the non-profit organization submit to its Board, the General Assembly, and the Governor a strategic plan recommending specific data projects to be undertaken. Section 32.1-276.5 requires that "every health care provider submit data as required pursuant to regulations of the Board". It is important to note that at this time, it is not possible to include a payor identifier that identifies specific HMOs or other types of plans.

APPENDIX J

SCREENING CRITERIA FOR COMPLAINTS THAT MAY ADDRESS QUALITY OF CARE ISSUES

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Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection

The VDH will investigate complaints where the quality of the health care services provided to enrollees by a health maintenance organization (HMO) licensed in Virginia, or one of its contractors, is in question. The quality of health care services provided by an HMO will be reviewed within the context of the enrollee's health plan coverage, mandated benefits, and the laws and regulations governing the provision of health care services provided by the health maintenance organizations and their providers contained within the *Code of Virginia*, 1950, as amended, and the *Virginia Administrative Code*.

Complaints concerning the quality of health care services can generally be applied to the categories that are listed below.

ACCESS TO HEALTH CARE SERVICES

- Geographic access limitations to providers and practitioners
- Availability of PCPs, specialists, behavioral and mental health providers
- PCP after-hour access
- Access to urgent care and emergency care
- Out-of-network access
- Availability and timeliness of provider appointments and provision of services
- Availability of outpatient services within the network (to include HHA, hospice, labs, physical therapy, radiation therapy)
- Enrollee provisions to allow transfers to other PCPs
- Patient abandonment by PCP
- Pharmaceuticals (based on patient's condition, use of generic drugs versus brand name drugs)
- Access to preventative care (immunizations, prenatal, STDs, alcohol, cancer, coronary, smoking)
- Access to HMO complaint and grievance procedures
- HMO enrollee notification regarding changes in the EVIDENCE OF COVERAGE and mandated benefits

UTILIZATION MANAGEMENT

- Denial of medically appropriate services covered within the enrollee contract
- Limitations on hospital length of stays for stays covered within the enrollee contract
- Timeliness of preauthorization reviews based on urgency

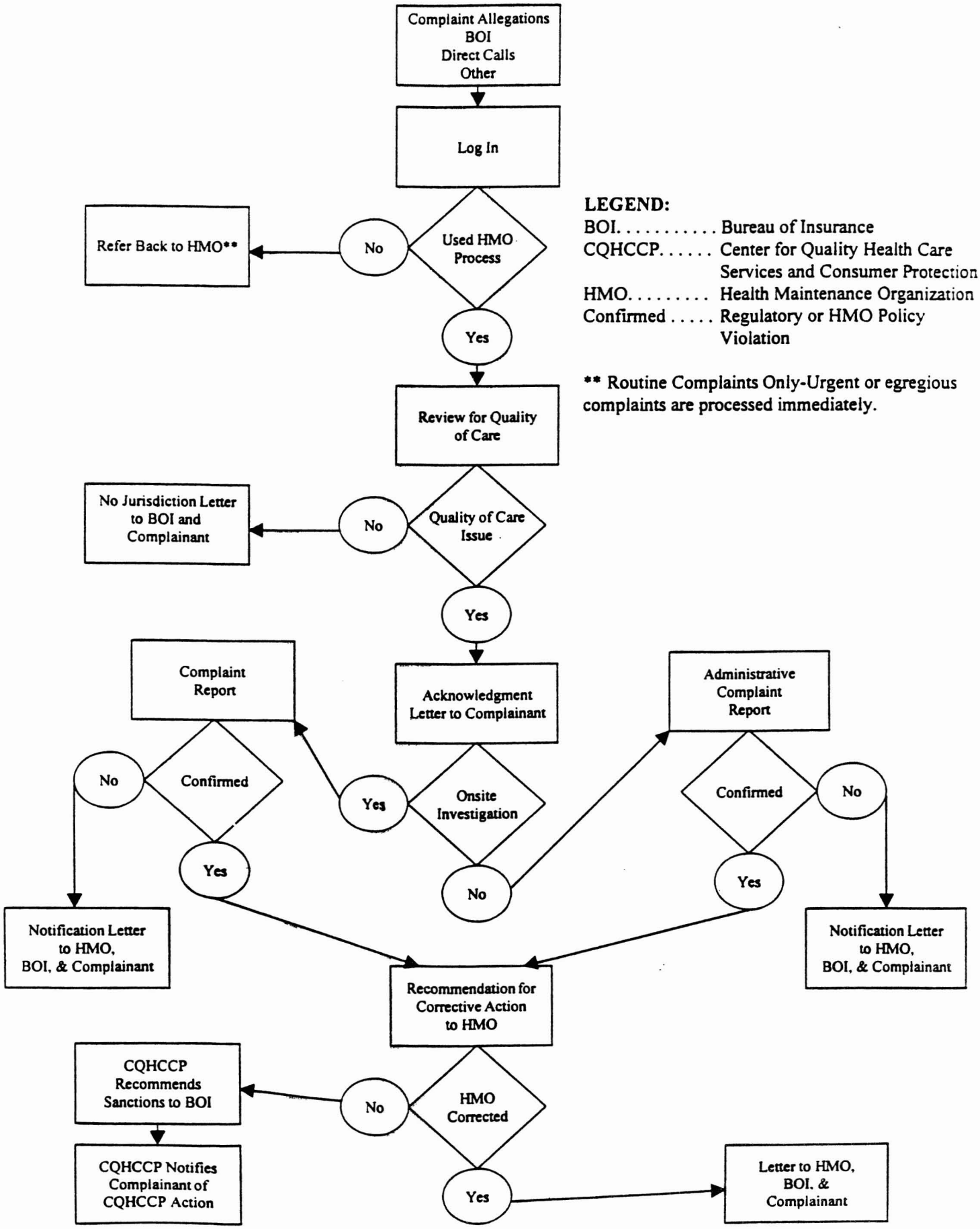
- Inappropriate setting for care i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
- Criteria for experimental care
- Unnecessary tests or lack of appropriate diagnostic tests
- Denial of specialist referrals allowed within the contract
- Denial of emergency room care allowed within the contract
- Failure to adequately document and make available to the members reasons for denial
- Unexplained death
- Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to progress to a more severe form
- Organ transplant criteria questioned

PRACTITIONERS/PROVIDERS

- Appropriateness of diagnosis and/or care
- Appropriateness of credentials to treat
- Failure to observe professional standards of care, state and/or federal regulations governing health care quality
- Unsanitary physical environment
- Failure to observe sterile techniques or universal precautions
- Medical records - Failure to keep accurate and legible records, to keep them confidential and to allow patient access
- Failure to coordinate care (Example: appropriate discharge planning)

The Center's expectation would be that HMO members had attempted to resolve their complaints initially by accessing the HMO's internal complaint resolution process and/or their employers' health benefits office prior to bringing their complaints to the Center unless the complaint was so urgent that it placed the patient or others in serious jeopardy.

The Center for Quality Health Care Services and Consumer Protection's HMO COMPLAINT PROCESS



LEGEND:

BOI. . . . . Bureau of Insurance
CQHCCP. . . . . Center for Quality Health Care Services and Consumer Protection
HMO. . . . . Health Maintenance Organization
Confirmed . . . . . Regulatory or HMO Policy Violation

** Routine Complaints Only-Urgent or egregious complaints are processed immediately.

APPENDIX K

FOCUSED ROUNDTABLE SUMMARIES

APPENDIX K: FOCUSED ROUNDTABLE SUMMARIES

Focused Roundtable for Providers

April 29, 1997
9 a.m. - 12 noon

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the Roundtable participants. He gave a brief overview of the Bill 2785, which has required the Commissioner of Health to submit by October 1, 1997 a study of the quality of care provided by managed care in Virginia. The Study Group is charged with exploring and recommending options for creating greater collaboration among state agencies to ensure quality care and for creating effective pathways for complaints and problem resolution, such as a consumer hotline. He identified the theme for the study as *"What is the role of the Commonwealth in managed care and ensuring quality of care?"* In addition, he informed the providers participating that the Commissioner of Health had selected agencies from the state government and private sector to form a study group to explore the problems and propose options for their resolution (hereinafter referred to as the Study Group.)

Dr. Daniels said the purpose for the Roundtable is to enable the Study Group to learn about providers' concerns and their suggestions for ways in which the quality of care can be improved. He drew everyone's attention to the definition of "Quality" before them. He acknowledged that the word "Quality" is very difficult to define and that the Study Group, which needs to complete its substantive study by September, could easily spend the entire four months simply debating the definition of "quality." In 1989 the Institute of Medicine conducted a study in which it looked at over 100 definitions of the word "quality," and ultimately created its own definition. Rather than spending time on this difficult issue, the Study Group looked for a definition of "quality" that has meaning and continuity with the Virginia experience. The working definition selected by the Study Group is that developed by the Virginia State Medical Facilities Plan.

Definition (from Virginia State Medical Facilities Plan)

"Quality of care" means the degree to which services provided are properly matched to the needs of the population, are technically correct, and achieve beneficial impact. Quality of care can include considerations of the appropriateness of physical resources, the process of producing and delivering services, and the outcomes of services on health status, the environment, and/or behavior."

During an August 1996 Roundtable meeting with the Commissioner of Health, the participants representing a diversity of stakeholders agreed that the following seven components of quality were appropriate for state oversight. The Study Group adopted these consensus components as a means to narrow the focus of the definition. The Study Group would be interested in learning what these components mean to providers in the context of their practices.

Seven Consensus Components of Quality (from August 1996 Roundtable):

1. **Prevention**
2. **Complaint Resolution**

3. **Access and Availability**
4. **Credentialing**
5. **Consumer Satisfaction**
6. **Improvement of Community Health**
7. **Outcome Measures**

Dr. Daniels then introduced the Roundtable facilitator, Frank Dukes, Ph.D., of the Institute for Environmental Negotiation at UVA. Dr. Dukes welcomed all of the participants and characterized the Roundtable as an informal opportunity for members of the provider community to talk with members of the Study Group. He noted that this was the first of three such Roundtables to be held, and that there would be additional opportunity in September to discuss the issues and look at the Study Group's draft report and recommendations. He reviewed the agenda and expressed the hope that everyone would have an opportunity to participate in the discussion, would speak with candor, and that the Study Group members should feel free to ask questions of the providers at any time during the meeting. He asked each participant to introduce themselves with their name and organization. [A list of participants is attached as Appendix A.]

The 7 Components of the Definition of "Quality"

The Roundtable participants were asked, *"What do these seven components mean to you as providers, in the context of your practices?"* The following is a summary of the major comments by Roundtable participants.

Outcome Measures (Component 7)

A number of participants said that outcome measures (Component 7) would be the most important criteria in determining quality. While all of the components are intertwined, quality affects patient outcomes most obviously.

The Dental Association representative said that the House Bill is directed at trying to assess delivery systems. As such, outcome data and measures are really the key to that assessment. He noted that 69.3% of dentistry is prevention. Prevention is costly and, in dentistry, may not save dollars, as compared with prenatal care. However, the outcomes of lack of prevention (such as loss of teeth) can and should be measured.

Community Health (Component 6)

Improvement of community health (Component 6) was endorsed by the Academy of Family Physicians representative as the highest priority. The Board of Health representative said it would be important to define the population base for community health; is community health defined by enrollees, the community at large, including the unserved or underserved population? What can be done to assure that these people have coverage?

Dr. Daniels noted that there is no exhaustive definition created with regard to community health. In listing community health as a component of "quality," the Study Group was thinking about impact of delivery systems

on the community at large. The Study Group was not specifically attempting to address the indigent issue.

One participant said that even if the study doesn't address the broader community, it is an issue that deserves attention. While the HMO's main focus is enrollees, some things they do can affect the larger community, such as education and prevention. The question is, who is really accountable for the larger community.

Another participant said that if the State is going to measure accessibility of health care, then it will have to look at larger community. The Study Group might want to focus on the impact of insurance on the community at large; whether it be an HMO or other managed care plan, it can impact what percentage of population remains that still needs care.

Continuity of Care

Continuity of care should be added as a component, because it has become an increasingly important issue as consumers switch jobs, move, or employers switch plans. Continuity of care is especially critical for some diseases.

Prevention (Component 1)

Prevention needs to be defined, because it can mean different things in different contexts. There needs to be a baseline understanding of this term and standards for preventive care. In the context of Durable Medical Equipment (DME), prevention enters into the picture at the time of diagnosis. To an emergency physician, however, education of proper use (e.g., safety seats, seat belts, poison, etc.) is the primary meaning of prevention. To the Board of Health, population-based prevention and looking at overall trends is important.

Survey Parameters

It is very important to determine *who* is measuring the quality. If it's the patient, the measures might be subjective. If it is some other group, the study might be more quantitative and statistical. It would be important to incorporate both types of measures, subjective and quantitative, so that the study is balanced. A number of participants underscored the importance of having a balanced survey, including measures of insurers, providers, and patients, and that one group should not be given more weight than another. It is especially important to survey the patients. Some care should also be given to which types of patients to survey. Right now, studies are determined by who is funding the study, which can skew the study results.

Access and Availability

One speaker noted that while outcome measures are, obviously, the bottom line, access and availability is the main issue in ensuring quality care. Most of the anecdotes heard about problems with managed care are from people who are sick and who have to use the HMO extensively. A person who is well, and may or may not be working on prevention, is not likely to complain. Those who need access to care are the people who are experiencing problems. So access is the main problem.

Access is a hot issue in other ways. Access of patients to providers is a key issue, particularly in areas that are rapidly growing. HMO law has a clause that states that HMOs must have a reasonable mix of providers. HMOs say, "Our panels are full, we don't need anyone else in your area." That is their justification for keeping a provider out. Then seven new neighborhoods are built, but no providers are available to service these people. So the restrictions on panels create a major problem; the plan limits the availability of providers who can actually provide the kinds of services that the plan says will be made available.

An additional issue of access and availability is the problem created by third party payers limiting the range of services that providers can make available to the consumer. For example, physicians have the capability of performing at a lower cost and greater convenience to the consumer a number of procedures in their office which previously were only available in hospitals. Yet physicians are often unable to make these procedures available to the consumer. It is up to third party payers to make the services available through local providers.

Optometry has full prescribing privileges for eye disease. However, optometrists have found that HMOs allow them to see patients only for vision care, which means that the patients have to be sent elsewhere for medical care rather than being served more quickly and at less cost in the optometrist's office. Optometrists then have to go through a big rigmarole to get their patients referred in a timely manner for appropriate care.

Q: Is this an issue of convenience? Or does this actually impact the services patients are receiving?

A: If the medical conditions can sustain a delay in treatment, then the service provided is okay. But if there are conditions that need immediate treatment, then the quality of care suffers. There is also an issue of cost of care; optometrists might be able to provide it at less cost.

Several people concurred that convenience is an issue that very much affects access and quality of care. Some patients might not be able to easily get to some providers. Who is included on panels does not always take into consideration the needs of the elderly, disabled, or geographic issues. People have to take time out from work to obtain medical care. So roadblocks to receiving care often means that people don't get the care they need.

Access and availability also means both access to both primary care physicians and specialty physicians. For example, one pregnant woman had to travel more than 100 miles to get a test done, because the plan didn't allow for a closer provider. In the field of plastic surgery, most HMOs exclude reconstruction due to trauma that did not occur while the patient was covered. There are congenital defects (harelip, back, other problems) which are therefore not covered.

Medically Necessary

The Physical Therapy Association representative said that the insurance company determines what is medically necessary, which causes many problems. For example, a physical therapist cannot do any therapy without a diagnosis code. In the case of a 2-year old rheumatoid arthritic patient, the company doesn't want to provide therapy because surgery might be needed in a few years. Other therapies have a limitation of 90-days; this limitation doesn't work for chronic problems. Also, physical therapists are treating more complicated pediatric

cases and cross-training in physical therapy is becoming expected.

The Virginia Dental Association said that the phrase "medically necessary" is a problematic euphemism. For example, one plan says that oral surgeons cannot do reconstructive surgery on a face if the person can maintain weight with liquids. It is one thing to say a treatment is not covered by the contract, and that it is a contractual issue. It is another thing to say the treatment is not "medically necessary," when in fact treatment is appropriate and acceptable but is simply not being referred and delivered.

We need to change our language. We need to determine whether a treatment, first, is appropriate or not appropriate. If it is appropriate, then it is either covered or not covered. It is misleading to talk about the medically necessary or unnecessary.

Q: In the case mentioned, what happens to the patient? Is there a complaint system?

A: What the physician must do, to make sure the patient receives the appropriate treatment, is to become hyperbolic. You have to exaggerate problems to the Nth degree to get the patient covered. The issue of having a consultant determining whether something is medically necessary is nothing but a smokescreen!

It is interesting how the discussion has moved from a definition of quality care for communities to individuals. This is important, because the problem with our current system is how it fails to meet the needs of individuals for whom discussions of the aggregate just don't work.

The issue of determining what is medically necessary means that judgment must be applied at some point. Today, the struggle is to determine the locus of that decision-making. Should the decision lie with the legislature, with HMOs, with individual providers (where it used to be), with a nurse over an 800-line, with someone who has an adversarial role toward the patient, or a group of local care physicians who are closer to the patient and will develop a "care protocol" for the patient? The speaker hoped for the latter. Just because we have a fair degree of comfort with the current system doesn't mean it is the best.

Judgment is needed in determining whether a treatment is medically appropriate. Then, if it is medically appropriate, other people can decide whether contractually it's covered or not. There is a huge difference between saying something is medically appropriate but is not covered, and saying that some third party has determined it is not medically necessary.

Timely Access

Timely access is an issue. Pharmacists have a problem in both acute and chronic situations where they may be required by formularies to change medications that have been ordered. It can take a long time to contact the physician or HMO to obtain their concurrence, sometimes as much as a one or two day delay in delivery of the medication to the patient.

Q: Is this a problem with just HMOs or managed care in general?

A: Managed care. More Pharmacy Benefits Managers (PBMs) are being used to manage prescriptions, but there are no federal or state statutes that establish oversight of PBMs. We are being asked by PBMs to make decisions on a monetary basis, not a professional basis. This is an infringement on our professional conduct.

Sometimes a switch in medication is made without the provider knowing about it. Other times the physician is called by the HMO or PBM, and asked to make a switch, regardless of the local pharmacist's recommendation. Sometimes the pharmacist can block a change, but often is not able to. This is clearly a case where the cost savings are for the HMO, not for the patient.

Q: Is the PBM a risk-bearing entity?

A: No. Some of the materials sent by the HMO to patients contains innuendoes about what is appropriate or not appropriate in terms of care. There should be some kind of mechanism for complaints by providers, to enable challenges to the HMOs' determination of what is medically appropriate.

The HMO does not always follow the latest research or recommendations on what is the best care, and there should be an established mechanism or path to challenge the HMOs on this.

Q: Did you say a drug could be switched without the pharmacist's knowledge?

A: (Physician answering) Yes. Calls for a change in drug can come directly from an HMO to the physician.

Q: So the physician makes the decision?

A: Not always. Sometimes patients will come back for a second visit with drugs that are close but not the same as that prescribed. On checking, we find that the pharmacist didn't know that the drug prescription had been changed. The medicine may be considered "pharmaceutically equivalent," but in reality, given that the patient may have a variety of conditions and drugs which need to be managed and monitored carefully to avoid complications and interactions, the drug is not exactly the same.

For example, one patient had been put on a drug that worked well. The patient switched to another HMO, which didn't allow this drug because of the cost. So the patient was switched by the HMO to another similar, but different, drug, to which s/he had a terrible allergic reaction and is now taking Prednisone for that reaction.

Another example is of a complaint received regarding a patient who was told that a drug was no longer available to her, when in fact it was available, and at a dosage that would have been cheaper for the patient. A number of questions arose from this complaint: Why was the patient's social security number

divulged in a letter? Why wasn't the cheaper drug given? Why was the patient not told the drug was still available? Where was the physician in all of this?

Patient Confidentiality

Patient confidentiality is a very real concern. Pharmacists transmit to the HMO all information regarding drugs, patients and physicians. Companies can track a physician's prescribing history because pharmacists use tracking numbers. So all of this information is in the hands of the HMO, which gives the HMO a great deal of power. The question is, are they really respecting the confidentiality of patients?

There are lots of roadblocks to doing what is right. Research may support a particular treatment modality, but access to that treatment can be limited by HMOs. To do what is right, you have to create hyperboles and play games to get around the roadblocks. Sometimes it works, sometimes it doesn't.

Q: Do you have access to a medical director to talk about appropriate care?

A: A number of speakers responded that this issue was problematic. Sometimes the medical director has no background in the medical specialty or is not familiar with the recent research. Sometimes the name of the medical director is not allowed to be given. Sometimes access is only available to case managers, and often they have no medical background, no nursing background, no background in science, and even no college degree. Sometimes they just have a high school diploma. This can be very frustrating as a lot of time is then spent explaining the issues, all while the patient is waiting for an answer. Sometimes, the person says they will get you an answer in a couple of days, but the patient is standing there needing an answer now. Because of this system, providers have to become "cheerleaders" and "pushers" to get the care provided to patients.

Denial of Coverage/ Denial of Care

Q: I'm hearing today that care is being denied. However, we hear from HMOs that care is not being denied, only coverage is denied. Can you speak to this? Is this a problem inherent in the system, when you place financial risk and medical coverage in the same entity?

A: A number of people, in responding, indicated that a denial of coverage can be tantamount to a denial of care when the patient has no other resources with which to obtain the care. A Fortune 500 CEO, for example, can afford to pay for a treatment that is not covered by a plan and, therefore, there is no denial of care. For someone else, who cannot afford to pay for the treatment out of pocket, the denial of coverage means that the care effectively is denied.

An additional difficulty is that those who are making decisions are not accountable to their individual Boards for the decisions made; thus the public has no protections from decisions made about medical necessity.

It is not really new for risk and coverage to be housed in the same entity. Insurance companies have been doing this for a long time. They insure against unforeseen circumstances and make decisionsabout coverage. Medicare operates this way. Under managed care, much more utilization review goes on than in other types of insurance companies. The only way to get around this issue is to have a fully socialized medicine which, of course, could be part of this debate.

A lot of the problem of housing coverage and risk together could be addressed by establishing a set of checks and balances.

Utilization Review Statute

Q: Is the Virginia utilization review statute used? Does it work?

A: For Durable Medical Equipment, patients are not generally aware of how to use the utilization review process. We tried to go through a Chapter 54 review but were told that DME wasn't covered and, in the case of an antibiotic, told it wasn't on the formulary. Some HMOs have processes in place to handle situations, whereas others don't. In this situation there was no process to go outside of these bounds. The patient either had to pay over $100 for the antibiotic on their own, or not get the drug. A physician made the determination that he did not want to change the prescription. So it was up to me to try to help the patient. Providers are put in the middle and have to expend huge amounts of time to try to resolve the problem for their patient. Yet, this is uncompensated time that providers spend on the patients.

The bigger question is whether the development of formularies is covered under the utilization review statute. Does the formulary have to be developed in accordance with the statute ["objective, clinically valid, and compatible with established principles of health care ... and sufficiently flexible to allow deviations from norms when justified on case-by-case bases"]?

Q: What steps have been taken to educate consumers and providers about the Statute?

A: The Medical Society publicized the statute in its newsletter. The Dental Association publicized the passage of law, but not more. Some responded that they cannot remember receiving any information from the Academy of Family Physicians. Several people commented that education is very important, and is everyone's responsibility.

Q: Does VDH have guidelines for procedures? Has the Bureau of Insurance defined procedures that would implement Chapter 54?

A: The Bureau of Insurance has a record-keeping requirement, and conducts reviews to assure compliance with the policy, but the major frustration is that it has received no inquiry from anyone who has tried or wanted to use the statute.

Q: Why is this?

A: One person responded that patients do not know about their right of appeal, and they don't know how to use the process. In one case, however, when a patient did try to use the process, the patient felt overwhelmed by the process and felt she had to hire a lawyer to file the appeal. That should not be the case. The HMO should provide a copy of the protocols to the providers when requested.

Q: Has anyone requested the protocols?

A: A physician responded that, yes, he had requested the protocols and received them by fax the same afternoon. However, he doubted that people not on the clinical side could understand all the language involved in the protocols.

A DME representative responded that she could not obtain lists of either the covered drugs or of pharmacy protocols, and that they were very difficult to obtain.

An HMO representative said that HMO newsletters do publicize protocols, but acknowledged that language used in the protocols may be difficult to understand.

Regarding prescription forms, the HMO assumed that another entity would have contacted *all* providers who write prescriptions to notify them of the imminent change in prescription forms, to come into force on July 1. Virtually nobody will be in compliance on July 1. One of the

reasons for this problem is that the law did not specify how or who would be in charge of implementing the law.

The representative for the Department of Health Professions said that, historically, insurers have been in charge of implementing changes. However, the view of that responsibility is changing around the nation.

Accountability

Various people made comments about accountability. One provider said that nowhere in the philosophy of HMOs are HMOs held responsible and accountable. Providers are held responsible, but not HMOs. HMOs are making medical decisions and therefore should be held accountable. Providers are held accountable for providing quality care by the patients, when in fact the decision makers are the payers or the HMOs.

The Department of Health Professions speaker said that, in Virginia, the question is still unsettled as to who should be accountable. Functionally, if someone is making a decision that affects care, then they are practicing health care and they should be held accountable. The questions of who should be accountable for licensing the decision-makers, who is functionally practicing, and how there should be mechanisms for accountability, are not

yet answered. The Department of Health Professions gets complaints about this issue from physicians in Virginia, as well as complaints from physicians in other states about decisions that were made in Virginia which affected a patient's care in another state.

A Dental Association representative mentioned what is known as a "gag" rule, whereby the provider is not allowed to inform the patient of all of the medical options that should be considered in their treatment [Note: HB 1393 prohibits this practice]. He suggested that State Boards should be more pro-active about dealing with the contractual issues and language in provider agreements, such as not being able to discuss all medical options.

The Physical Therapy Association representative mentioned a recent case of a federal employee in Northern Virginia who went to her PCP to get a prescription for physical therapy. The physician started to write out the prescription, and the patient said she wanted to use the "point of service" option. The physician said he could not do that because he would lose a "bonus" from the HMO. The PT found this difficult to believe and checked with the managed care organization, which confirmed that the issue of the bonus was true.

Boards need to hold the providers accountable for these kinds of decisions.

This situation creates a double bind. Providers are faced with a terrible dilemma of either not signing a managed care contract, and thereby losing, say, 70% of their patient base, or signing a contract and thereby dying slowly because they won't be able to provide the standard of care that they feel is appropriate. The wrong entity is being punished.

Dr. Daniels commented that the point of the mandated study is to deal with what is possible to accomplish, and what can be changed in the managed care system. The Study Group wants to help monitor the quality of managed care and stay away from punitive measures.

One person said that a problem created by shorter contracts is a lack of continuity in care and accountability, as well as an understanding of what it going on for the patient. An option to improve this situation would be for plans to establish contracts to providers for three to five years, to ensure better continuity of care and accountability.

Home health care accounts for less than 3% of managed care. A problem for home health care is that the number of authorized visits are limited. Often home health care providers are forced to discharge the patient before the patient's treatment is completed.

What Works, and What Is Needed?

In terms of what is working now, HMO enrollees will be given a phone number for complaints, and providers hopefully also have this number, which enable them to follow up with complaints. The phone number will be on the enrollees policy, and questions regarding quality of care will be funneled to the Center for Quality Health Care Services and Consumer Protection in VDH. Also, pharmacists are required to post the phone number for the Department of Health Professions.

The Virginia Hospital and Health Care Association representative said that some general education about the new statute would be worthwhile, and offered resources from her organization to help make it happen. She also noted that the percentage of the population affected by insured plans providing managed care is only 25% of the population in Virginia. The Study Group cannot address Medicare or ERISA. It is important to be realistic about how far-reaching these changes will or will not be.

One participant stressed the important of creating a position for someone who will help consumers navigate through the managed care plans. This person should act as an ombudsman rather than an arbitrator, and should help consumers regardless of whether they are covered by ERISA, Medicare, or a managed care plan. To be able to resolve complaints and understand the system should not require the threat of court action; it should just take "two reasonable people" to sort through the options.

Q: Should this kind of assistance be provided at the state level? Or should it be offered internally, within the plan?

A: The HMO representative said that there are customer representatives currently employed by plans. Sometimes these people can answer basic questions, but with more difficult questions someone else will usually need to provide assistance. If the issue is coverage, then more is at stake than "navigation" which can be considered simply an administrative problem. The hope is that by formalizing access to a third party through promulgation of the phone number, people will obtain the assistance they need.

Q: Let's say that a person covered by ERISA with a complaint makes a call to the VDH Center for Quality Health Care Services and Consumer Protection. What happens?

A: Complainants would first be referred to their Employee Benefits Manager, and ultimately could be referred to the Department of Labor.

The HMO representative said that, hopefully, the person would go to his/her employer first. Also, HMOs are required to have an internal grievance process.

Q: If I am fully insured, subject to state law, what can the VDH Center for Quality Health do for me?

A: That would depend on the nature of the complaint. The Center would listen to you, and would first ask if you had talked with your insurer. If the Center determined a quality of care issue existed, it would conduct a formal complaint investigation with the HMO and the results of the investigation and resolution would be communicated to the complainant. The Center has received very few HMO complaints to date and those they have received have been resolved favorably.

It seems like there is a need for a third person neutral who can provide real assistance. Patients who make calls to VDH often don't seem to get the help they need. Also, the issue of having internal review with the insurer raises the question of whether such a review would be unbiased, and whether there is a need for something over and above this.

There needs to be a mechanism to make sure HMOs provide sufficient information on their grievance process, how many complaints are received, and how they're resolved, because the number of complaints published make it seem like there isn't a problem.

One provider suggested that it could be helpful to come up with a uniform form for providers that states the recommended treatment, indications of treatment, and the probable effects of not following treatments, just like the kind of form used on a board exam. Such a form would take care of a great deal of problems.

Another provider suggested that the HMO coverage does not always meet current standards of acceptable care. Protocols for certain diagnoses are sometimes old, not reflecting more recent research. What can we do, how do we go about disagreeing with the general protocols?

Q: Is there a mechanism for providers to disagree with protocols?

A: The HMO representative said that a cookbook approach to care makes her nervous. The key would be "outcome mechanisms."

Another provider suggested the need for an appeals mechanism where providers who feel that protocols don't meet appropriate levels of care could appeal the protocol.

Concluding Comments

To conclude the meeting, each provider was asked to provide a final comment or recommendation for consideration by the Study Group.

Virginia Optometry Association: The priorities should be to ensure patient access to providers, to ensure that the HMOs follow the laws, and that providers have access to panel membership.

Old Dominion Medical Society: It appears that a segment of population is being ignored, and the question should be addressed of how you get certain segments of the population to the providers of care, whether it be the DME, physicians, or whatever. Secondly, the issue is to make sure that everyone understands the language that is being used and their full range of options.

Virginia Hospital and Healthcare Association: We are dealing with an immature marketplace, which is reflected in the levels of insecurity, hostility, and raging hormones. What we need to do is ask the question, "How can we help this marketplace grow well?" The key is to hold people accountable for their decisions. Health plans need to be held accountable. We also need to find ways to equip small businesses with ways that they can document the performance of plans along the seven identified dimensions of "quality."

Virginia Academy of Family Physicians: Third party payers should be able to measure requests for providers, and determine who can provide that service best. There is a notion now that if someone doesn't fit in the system

that they're not accountable. This is not true. So third party payers should have a credentialing process to make sure that providers perform services that are within the knowledge base of that provider. For example, a provider should not be denied the opportunity be credentialed merely because of geography.

Virginia Physical Therapy Association: The major issue is access and availability. There is also a need for patient advocacy and education in managing and navigating the managed care system.

Board of Health and Nurses: Patient advocacy is essential. There is also a need to find a way to address the issues of the under and un-insured.

Hospital Home Health: Providers should not have to be advocates for patients; patients should have a way of knowing their options and be able to easily access the system on their own.

Old Dominion Medical Society, rep #2: We all need to be accountable for the health care system that develops. Today, doctors are evolving into Medical Managers, where half of their time is spent on paperwork and maneuvering through the system. The issue of quality is *passé*, an issue of 25 years ago. We need a different notion of what quality is today; for example, if I am to be accountable for management then you need to find a way to oversee and determine the quality of management provided, in addition to the quality of actual health care.

Virginia Association of Durable Medical Equipment: Accountability is the key issue. Accountability should be shared by all decision makers. The Study Group should look at educating and resolving issues for the individual patient, to make sure that the individual patient knows how to use the system, whether it be through an ombudsman or other mechanisms. Most of the problems today arise because people don't know how to use the system.

Virginia Pharmacy Association: Accountability is the key word. Everyone, from patient to the insurer, should be held accountable for their decisions. Pharmacists are being forced to make more decisions based on policies set by HMOs. Patients and providers need to be able to have more input into the development of policies set by HMOs.

Virginia College of Emergency Physicians: In emergency cases, access and availability are not an issue. We treat everyone who comes through our doors. Two laws do affect our work: (1) the prudent lay person law - is the managed care facility the one who should decide whether the prudent lay person law applies?; and (2) the law requiring, beginning in July, that managed care will provide timely access to PCPs. The study group needs to find a way to monitor the application of that law.

Virginia Chiropractic Association: We need an independent organization to which these problems can be submitted. The organization should be staffed by a mix of providers, citizens, etc., to take a look at all of the issues such as HMO policies, the number of providers, access, protocols, etc.

Medical Society of Virginia: Quality care requires access and availability at all different levels. It also requires accountability by all persons in the process. It requires education regarding provider care, a complaint process

and review, and education to providers of data on how providers can improve their practice in managed care.

Dr. Daniels and Dr. Dukes thanked everyone for participating in the Roundtable and sharing their views. A report on the Roundtable session will be posted on the website address **http://www.vdh.state.va.us** and also mailed to attendees.

Focused Roundtable for HMOs

May 6, 1997
2:30 p.m. - 4:30 p.m.

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the Roundtable participants. He gave a brief overview of House Bill 2785, which requires the Commissioner of Health to submit by October 1, 1997 a study of the quality of care provided by HMOs and other forms of managed care in Virginia. The study is charged to explore and recommend options for creating greater collaboration among state agencies to ensure quality care and for creating effective pathways for complaints and problem resolution. He identified the theme for the study as *"What is the role of the Commonwealth in managed care and ensuring quality of care?"* In addition, he informed the HMOs representatives that the Commissioner of Health had selected representatives from the state government and private sector to form a Study Group to explore the problems and propose options for their resolution.

He noted that the Study Group was convening Focused Roundtables for the three groups of providers, HMOs, and consumers/purchasers so that the Study Group members could hear from and interact with these groups regarding ways in which managed care in Virginia might be improved. He expects that summaries of the Roundtables will be posted on the internet by the end of May at the website: Http://**www.vdh.state.va.us.**

Dr. Daniels then introduced the Roundtable facilitator, Tanya Denckla, C.M., of the Institute for Environmental Negotiation at UVA. Ms. Denckla welcomed all of the participants and characterized the Roundtable as an informal opportunity for representatives of HMOs to speak with members of the Study Group. She reviewed the agenda and expressed the hope that every HMO would have an opportunity to participate in the discussion, would speak with candor, and that the Study Group members would be asking questions of the HMOs throughout the meeting. She noted that the Roundtable had a challenging agenda because they would be trying to discuss in two hours a number of important issues that are complex and technical in nature. Because of the time constraints, she encouraged all participants to keep their remarks brief and to the point. Recognizing that people would not have time to say everything that they might wish, she noted that there would be an additional opportunity in September for HMOs to discuss and comment on the Study Group's draft report. She asked each participant to introduce themselves with their name and organization, then proceeded to describe the general outline of questions for the session. Twelve questions for the Roundtable were drafted and mailed in advance to HMO Roundtable participants. These questions are numbered below, Q1 through Q12. The questions were grouped into three subject areas to facilitate discussion: Quality Improvement, Quality Patient Care and Medical Necessity, and Quality Providers.

Reporter's Note: Comments are attributed to representatives of the following HMOs that were invited to participate in the Roundtable. In some cases more than one representative of the same HMO may have spoken, but we have simply indicated the HMO. We have also indicated when comments have come from the Study Group or Facilitator.

Whenever possible, we have indicated the speaker where it seems important to know which organization is

speaking; in other cases some questions and comments were made that did not seem to require identification as they were generic in nature. In a few cases we could not identify the speaker because they were not clear from the tape or notes.

HMOs Represented
Aetna/ US Healthcare
Capital Care, BCBS
Chartered Health Plan
John Deere Health Care
HealthKeepers, Trigon
Kaiser Foundation Health Plan
MAMSI
NYL Health Care Plans of the Mid-Atlantic
Prudential
QualChoice of Virginia
Sentara Health Systems

Organizations Represented on the Study Group
Office of Health Policy, VDH
Center for Quality Health Care Services and Consumer Protection, VDH
Joint Commission of Health Care
Virginia Association of HMOs
Virginia Department of Health Professions
Virginia Department of Medical Assistance Services
Medical Society of Virginia
State Corporation Commission, Bureau of Insurance
Virginia Hospital and Healthcare Association
Virginia Chamber of Commerce
Virginians for Patient Choice

Quality Improvement

Q1: What are HMOs doing to ensure quality that was not being done in the traditional fee-for-service environment?

Prudential: There is a lot that we do from the outset. We credential providers who wish to join the network, which involves collecting a lot of data, and then we recredential them every two years. We also use about 60 measures to assess the plan on an annual basis. These include measures of pure clinical quality as well as service measures such as the speed of answering telephones. Many of these measures are recommended by "HEDIS" (Health Employer Data Information Set) but they also include access to providers and availability of providers. We have standards that we've set and communicated to providers. If we find our standards are not met, we work

with them to get them back up to where they should be.

Kaiser Foundation: We have multiple member and provider complaint processes at multiple levels. Also, we have an extensive prevention program that would not typically have been found in the traditional fee-for-service setting. Prevention includes regular scheduled exams as well as outreach about the importance of proactive and screening exams such as mammogram and children's check ups. This kind of outreach was not done by the traditional system.

Prudential: Outreach is key, because this is the way we are finally reaching people who are generally healthy and were not traditionally reached. If you look at the measured baselines of some of these impacts, you see improvement by up to 20 percent in these measurements, based on just a few years of this kind of outreach.

Chartered Health Plan: The outreach done by HMOs is not just a telephone outreach, but an in-home outreach program. We identify members who are potentially high risk, and do case management and follow up with these members.

Capital Care: In addition to outreach, we are also doing research on the general systemic barriers to care across our entire population, making some interventions, and then re-measuring to see if we've had an impact.

Aetna/US Healthcare: To judge a health care system, it is important to look at disease prevention as well as disease management and intervention. We've also developed very extensive disease management programs, where we establish protocols that are often developed in conjunction with health care agencies. The structure of the current health care system is much more comprehensive to ensure overall quality care.

QualChoice: For the first time, managed care is inviting customers for insights and feedback about their care. We are constantly asking for feedback through provider and customer surveys, to find ways in which we can improve the quality of our service.

HealthKeepers, Trigon: One difference is the consistent loops of information used by HMOs to collect data on both service and care. Particularly with regard to the provider community, this kind of information has not been readily available before; providers were not able to know trends in the marketplace, what their colleagues were doing and how they compared. This didn't happen with fee-for-service.

John Deere: The general population benefits from this too, because as providers get feedback they will improve their care to all purchasers, whether or not they are covered by our plans.

Question from Study Group member: Are the quality mechanisms migrating over into the general population, and if so to what degree?

Capital Care: The quality program extends beyond just the HMO to point of service products and, to a lesser extent, some of the credentialing. In terms of complaints and preventive programs, they extend to our general population as well.

Aetna/US Healthcare: There are different packages, some for self-insured, which are offered through and

designed by plan sponsors. We've offered all of our benefit packages to plan sponsors. We have extended these programs to all our products, and this has been beneficial to all customers because it has improved outcomes. So I do think there has been some migration of products offered by managed care to the rest of the population.

NYL Care Health Plans: Some of us offer several products, but there is a natural boundary so that a number of these quality measures cannot migrate. They might be bounded by the contract; a lot of these quality issues are accomplished through contractual relationships. However, to the extent that anyone is using the services of a doctor participating in any managed care program, the quality is improving overall.

Sentara: It's much harder to demonstrate products in non-clinical programs. You can't use traditional insurance models with current patients, because they didn't have the contractual agreements back then.

Question from Study Group member: To the extent that providers are credentialed into networks, what components are involved in the credentialing process and approximately what weight is given to each component?

NYL Care Health Plans : It's hard to generalize across the plans. If you look at national statistics, it is clear that board certification is a good qualifier. We're all struggling to find markers. One of the more obvious markers that's widely accepted is board certification. Nationally, in HMOs, 80% of participating physicians are board-certified while, for the overall population of physicians, 65% are board certified. Most of us look for board certification as an indication of quality.

Aetna/US Healthcare: We also look at the doctor's use of products, type of medicine practiced, hospital privileges, whether there are any state sanctions, and we try to ascertain whether the doctor meets certain standards. We also conduct individual interviews. There are a number of ways we try to ensure that quality care is provided to our customers. This also relates to the first question because, in fee-for-service medicine, a physician only needed a license to practice.

Kaiser Foundation: Beyond the initial credentialing, we do a re-credentialing every two years in which we look at their records, complaints received, and do physician reviews, to ensure that physicians are meeting our quality care standards.

HealthKeepers, Trigon: Most of our HMOs also review the office environment in the initial credentialing and recredentialing. We look at whether they have the space, supplies, and staff to be able to handle the patients and meet the standards of HMOs quality of care.

Question from Study Group member: Is economic credentialing a part of credentialing a provider? Length of course of treatment? Average charges per course of treatment for a particular physician?

Aetna/ US Health Care: Our philosophy is "open access, open choice." We try to bring in all physicians who meet our criteria.

Prudential: We don't really have that kind of information about physicians, before they are credentialed the first time. When they are recredentialed, we do look at some of the utilization data. Are they more of the outliers?

Do they have sicker patients? We frequently meet with the providers to understand the data. Often there are good reasons for these trends. We also talk with providers more than just every two years. We go out and talk to physicians, and to educate them about how their peers are doing things in a more efficient manner.

NYL Care Health Plans: The problem is that usually there is not just one variable. Usually a network of patterns is visible from doctors who are providing poor care. During reaccreditation, these should be explored and identified.

Q2: What mechanisms are available for providers to present issues and concerns regarding quality? For consumers?

John Deere: In addition to dedicated customer service lines, we provide a dedicated toll-free line for all providers to call in to ask questions. For providers, we have a local quality improvement committee that meets every other month. Local physicians serve on this committee. For our customer service lines, we have customer service representatives who have access to all information. We take walk-ins, phone calls and letters.

Aetna/ US Healthcare: The Medical Director has a credentialing committee, which is a forum for physicians to provide information to HMOs and to discuss their concerns. Medical Directors also serve the function of taking calls from providers, to determine whether there the provider's issue concerns a physician or other aspect of quality care, and to be an advocate for the physician.

MAMSI - We have a unique contractual relationship with our physicians. At MAMSI physicians are contracted with through an organization called Physicians Health Plan, Inc. which is a subsidiary of MAMSI that is totally controlled by physicians. In essence it is a physician's Board that can serve the function of receiving complaints and concerns from physicians. So physicians will not only contact the HMO Medical Director but also often contact the Board, which then brings the provider concerns to the HMO.

NYL Health Care Plans: The opportunities for feedback from providers seem almost endless. Our plan was founded by doctors. Doctors sit on our Board, on peer review, and head the credentialing committee that meets once a month. We have a segment of our customer service department that is dedicated specifically to provider concerns, plus a segment of our client relations department that is geared specifically to providers. If none of these avenues meets the doctor's concerns, they can and do call me. Doctors are not shy about pursuing the interests of their patients or their own interests.

Question from a Study Group member: In the previous provider focus group, the issue of providers' concern about retaliation or somehow being black-listed was raised several times. Can I hear some discussion of this?

MAMSI: I have an anecdote about this. There was an OB/GYN physician and oncologist in our network who, both, believed that we had denied them from aggressively pursuing some of the issues that they felt were important. Our form of "retaliation" was to invite them to participate on our Boards, which they have accepted. They are now helping us to understand some of the issues they felt were important as well as participating in the decision making.

Capital Care: Members of the Medical Society of Virginia serve on our peer review committees. These

physicians have given us very specific feedback. They have created an office environment measurement tool that we now use. They have led us to change our benefits for diabetic education. So their feedback has resulted in demonstrable changes that were needed.

Chartered Health Plan: We invite physicians to meet with us on a quarterly basis for the sole purpose of giving us a sense of how the HMO is doing, so that we can make adjustments to meet the needs of the provider.

Sentara: We have a strong relationship with the Independent Practice Association (IPA); this is a new liaison that doctors can use. As an integrated health plan, we have a unique opportunity to work with physicians not only as providers but also as our medical staff. We have a Chief Medical Officer who is Chief for both the plan and the hospitals. Our Chief Medical Officer and his staff of other physicians meets regularly with the teams of emergency physicians, cardiologists, etc., to both gather and act on their feedback. I don't think physicians have ever had more input. Two years ago the whole organization went through a major reorganization and strategic planning process, and physicians played a major role in this.

Aetna/US Healthcare: The issue is how information flows back to the HMO. A lot of that has to do with the structure of the organization. In health care, we have three basic divisions: health care delivery, operations, and marketing. Health care delivery is directed by Medical Directors, and reviewed regionally on a monthly basis and nationally on a quarterly basis. Information filters up to us, and then back down. Medical Directors act as a kind of conduit for information.

Question from Facilitator: Regarding the issue of fear of retaliation, are there mechanisms for anonymous or confidential feedback?

Prudential: As far as the retaliation issue, if a provider has a problem with what we're doing, we really want to hear and interact with that provider. The provider does not need to give information about the specific patient, but does need to give us general information that we can act on. We take patient confidentiality very seriously, and recently let two physicians go who innocently divulged information about a member, and there was no second chance. It's hard to set out a proclamation that, "we're not going to retaliate." If a physician submits a complaint, and we act on it, then that filters back to the physician community and instills a sense of confidence that there won't be retaliation.

NYL Care Health Plans: We made it very clear in our newsletter that we are very strong about our policy to encourage physicians to advocate for their patients. We just ask that physicians don't libel or slander us, but it is okay for them to file any other kind of complaint. Every single termination over the last two years has been because of concerns over quality of medical care, not because of a complaint that they made.

Question from Study Group member: It seems that the closer the provider is to the Medical Director, the better. It sounds like confidentiality is not a problem. How would you react if there were to be a "for cause" clause in the contract?

A number of people answered that "for cause" clauses already exist. Either party can terminate contracts if they give 60 or 90 days notice. Termination "for cause" usually occurs only after a great deal of effort has been made to work with the physician. One HMO said that they would normally give a physician two to three years to try

to come into line with the norms. In cases of termination "for cause," there is a due process system to address appeals.

Study Group representative of Virginia Association of HMOs: Recent data for Virginia shows that voluntary terminations by physicians is about 2 to 4%, which is very much in line with national norms. These includes terminations for any reason, whether it be retirement, moving, or other reasons.

Question from Study Group Representative of the Bureau of Health Insurance: We receive a lot of questions and allegations from physicians indicating they are concerned about saying things for fear of retaliation. So the perception of possible retaliation, whether or not it is reality, is there. One of the purposes of this study is to make recommendations for changes in legislation or regulations. What ideas could you share as to how we might remedy this situation through a change in legislation or regulations?

Study Group Representative of the Virginia Association of HMOs: There is already legislation on the books that addresses this issue. The Utilization Review Statute, Chapter 54 of title 38.2-5400, adopted two years ago, prohibits the HMO from retaliating against providers for advocating on behalf of the patient. It is not a question of needing more legislation and regulation.

Study Group Representative of the Medical Society of Virginia: This is a major issue. We're saying, especially to doctors in Northern Virginia, you've got an 800-number to call with your concerns and complaints. But they are unwilling to use that number. So the question we're asking is, why would doctors say that they won't use the 800-number? Because of fear of retaliation?

Sentara: Working on both the hospital and practice side, I have rarely met a physician who is reluctant to complain. Doctors are fairly vocal about their concerns. The reality doesn't fit the paranoia. When you look at the numbers of terminations in the last few years, the data just isn't there to justify the fear.

Question from Study Group member: So, your view is that the physicians don't let this build internally, and that they freely bring their concerns forward?

Aetna/US Healthcare: Perhaps one big thing that could help is to inform physicians that the HMO provider turnover rate needs to be reported to our major purchasers. So if purchasers find that we have a large doctor turnover rate, that is seen as problematic for the HMO. So this is an incentive for the HMO to try to work with doctors and keep them on board. Perhaps it would be important to let doctors know how important a low turnover rate is for sales.

Capital Care: We found that our complaints were relatively small in number, but we realized that we are only as good as the information that we receive from our providers. So we formally decided to make a goal of increasing the number of complaints. We knew there were concerns, and we needed to find a way to obtain them. We published this goal in our newsletter, and told people the process and outlet for their concerns. Since then we have seen the numbers of complaints increase, and that is exactly what we wanted in order to see what was going on for our members.

Aetna/US Healthcare: Doctors rarely complain anonymously. We employ professional service coordinators,

whose function is to see each practice in our network at least three times each year. This a very important mechanism for feedback.

Prudential: These provider relations people usually focus on certain types of practices. If we get a problem over the phone lines, these people will usually be called in to deal with the issues. If it's a clinical issue, it will be brought to me. We also have member rights and responsibilities that we publish and send to members. Perhaps we should think about having physician rights and responsibilities, where they understand what their right is, yet also their responsibilities?

Study Group Representative of the Virginia Association of HMOs: It sounds like the issue is a failure to communicate. Whether or not you call it physician rights and responsibilities, the Association could craft some of the concerns, could get four or five points of what is available to physicians, and publish it so that we could get rid of this unfounded paranoia, which I hear about anecdotally. We've heard that terminations are very, very few, so it really seems the issue is communication and packaging that communication.

QualChoice: If your data, from the Medical Society, differs from ours in terms of the termination levels, please let us know. It sounds like, thus far, the low level of terminations is unrefuted. So if the termination levels are that small, the question becomes whether fear of retaliation is more a perception issue than reality.

Study Group representative of Virginians for Patient Choice: Sometimes I hear that there is an A list and B list of providers. As a patient, I can ask to use a particular provider, and the HMO can say that the provider is not available while the provider says they are in the network. This kind of experience has led people and providers to believe that there is an "A" list that receives referrals while the "B" list is those who complain. This kind of retaliation would not show up in termination data, it would be more a procedural retaliation to squeeze people out.

NYL Care Health Plans: The HMO is not so organized or sophisticated to accomplish this, even if we wanted to do it, which we wouldn't. That kind of practice hurts us in the long run. If we ignore the problems, then we will eventually lose because the physicians have a choice as to which network they wish to join. We are not so dominant that we can afford to lose our physicians. None of us is holding a gun to the head of providers, because it is in our interest to find out what is going on, what is going wrong, in the community. We don't need legislation to spell out a specific procedure for employees who are worried about the CEO. Paranoia doesn't call for changing legislation.

Study Group Representative of the Virginia Department of Health: **Do a lot of the concerns expressed extend to non-physician providers? Do the same mechanisms and procedures apply across the board?**

Numerous people responded that, yes, the same mechanisms and procedures apply to all.

Quality Patient Care and Medical Necessity

Q4: Is the Virginia utilization review statute (Chapter 54, Title 38.2) sufficient to ensure adequate mechanisms for resolving disputes in medical necessity determinations? and

Q5: How do HMOs obtain the services of the "peer" required in 38.2-5408.B?

QualChoice: We use the statute very little, as our basic decision making is left to the Primary Care Physician (PCP). So we have had to do very few medical reviews. When we have had determinations, our Medical Director is always involved. We obtain peers from our provider community, and we also use outside resources to help us make a determination.

Q6: How do you educate your members and providers about the review option?

QualChoice: It is in their contract.

Question from Study Group member: Are specialized services carved out by the PCP and mental health multiple options?

MAMSI: Purchasers usually carve out services to provide what they might feel they can do best. Purchasers ultimately decide.

Study Group Representative of the Virginia Association of HMOs: **In the last Roundtable providers indicated that they felt that decisions were made by HMOs that were not in the patient's best interest, and that were left "flat-footed," without recourse. It was amazing that the providers at the Roundtable had not ever used the statute, and were not familiar with the statute. So what we're wondering is, if there's a UR question of medical necessity for, say, durable medical equipment or for a formulary drug, and if the normal processes that you use for some reason don't work, is that the kind of decision that could go through the appeal process?**

Aetna/US Healthcare: That's a complicated question. Some of this is clear cut, other aspects less so. The question is whether the services meet general standards of care, not necessarily the physician's standards of care. First, the case would go to a reconsideration group, then it would go to a member of the medical community which would include the Medical Director, and if the dispute was not resolved at that level, it would then go to mediation. So there are multiple levels of dispute resolution that members can use.

NYL Care Health: The statute is almost never used. The appeal process provided by the UR is not used, partially because physicians are not familiar with it, but usually because the problem is resolved at a lower level about what is actually covered by the contract and what is medically necessary. What is appropriate coverage is not so black and white that people can take a hard stand. For the most part, people are profoundly interested in the well-being of the patient, so accommodation often occurs.

Study Group Representative of the Bureau of Insurance: **At the last Roundtable, one provider had tried to use the review process. Could you give some numbers on what you mean when you say the statute is "almost never used?" Where is it being used?**

NYL Care Health Plans: We used it only a handful of times in the last two years.

Prudential: We've used it only one or two times since the statute was enacted. What we've done since the statute was enacted is review the whole compliant process. At the reconsideration level, if we decide we goofed and it doesn't make sense, we give it to them. We once had about 100 reconsiderations per quarter, and now

we've gotten it down to about 32 or 33 per quarter. Of these, only one got to what we would consider an appeals level.

Question from Study Group member: Has the statute provided an incentive for HMO's to resolve disputes before they get to an appeals level?

MAMSI - We wanted to make sure that when something was denied, it conformed with the law. So rather than looking at just that piece, we would look at the whole appeals mechanism. All of it is part of the appeals process, from reconsideration onward.

Capital Care: There has been a lot of change in the appeals and review process in the last two years. HMOs have done a lot to improve their own internal mechanisms since the statute was enacted.

Study Group Representative of the Medical Society of Virginia: **How are you selecting companies that you are subcontracting to, such as pharmacies, and what do you do to ensure patient confidentiality? One case brought to our attention at the last Roundtable involved a situation where a patient got a letter from a drug company with personal information about the patient in the letter, in which the drug company told the patient that the drug doesn't exist, when in fact it does exist. What quality values do you place on the entities with which you subcontract?**

Capital Care: We do a review of these entities, very similar to the NCQA (National Committee on Quality Assurance) review and standards that we hold ourselves accountable to. So we look at their quality improvement plan, accessibility of their network, how they have credentialed networks, and we pull records and patient charts. They are required to periodically and frequently report on the things they have approved and denied. There is an onsite survey with the entity before we contract with them. Thus, we hold subsystems accountable for the same things that HMO's are responsible for.

MAMSI: There is a great deal of difference between plans. Purchasers are carving out certain components that make it difficult for an individual provider or consumer to catch.

Kaiser Foundation: If the individual plan is NCQA-approved, and if they have delegated or carved out particular services, they are required to meet the same standards in overseeing that carve-out to ensure they still meet NCQA standards. So the question is how do they approach quality oversight? If the purchaser doesn't do this, then the plan has the responsibility to deal with this.

Health Keepers, Trigon: There are services that an employer may carve out, that the plan doesn't provide at all. This is in contrast with services that the plan might subcontract and delegate. We need to be careful that we are clear about the services that the employer has chosen to carve out and go directly to a member. We can provide the patient some assistance and direct them back to their employer. But in those circumstances, there may not be much else we can do. Pharmacies would be an example of this.

Questions from Study Group Representative of the Department of Health Professions: **We received an unsolicited letter in the last week regarding an issue in dentistry. The issue concerned a report submitted by a provider recommending the removal of the patient's impacted molars, which was subsequently**

denied by the plan in a letter which said that this was not symptomatic and did not require removal. This is a situation in which someone who hasn't seen the patient and cannot examine the patient is substituting their judgment about what is or is not essential. This is the kind of situation that everyone here wants to avoid. What can we give to people to assure them that this is abnormal, and that it will not be the norm?

Capital Care: I would wonder if the dentist had contacted the medical professional who made this decision. That is where we want the dialogue to start. The provider may think there is some big bureaucratic process to follow, but they should just call the HMO and do whatever is needed to contact the person who made that medical decision.

NYL Care Health Plans: While all of us would like HMOs to stay out of the practice of medicine, not all decisions made by treating physicians should be deferred to. We had an incident of a woman in Maryland who needed both medical and psychiatric treatment. The medical condition was treated first in a hospital. The physician then wished to keep the patient in the hospital, while we pointed out that hospital did not have psychiatric facilities. In that kind of dispute we cannot always do what the physician wants. On the other hand, we certainly don't want to be in a position of making medical decisions for the physician. It is important to be clear about the distinction between medical decisions that concern the treatment of the patient and decisions that might depart the boundaries of the contract. These are very different types of decisions.

Health Keepers, Trigon: The other mechanism that HMOs have in place is to make sure that any information concerning coverage is distributed after we receive information. If errors are made then we notify physicians and members stating their right to appeal. We want the physician to come back to us and tell us if we've made a mistake, rather than sending a letter to the state.

The group concurred that it is a common practice among all HMOs to send a letter stating the right to appeal.

Sentara: In the situation described, perhaps there was a lack of documentation or lack of clarity on the part of the dentist. I do not believe non-medical professionals would make or attempt to make the kind of decision described. The appeals process is sent out with every single denial, so I would hope that the dentist would call right back or use the appeals process in place.

MAMSI: This is a problem because providers don't always have the ability to fully document cases in a way that HMOs require. If there is a pattern of this, then perhaps the HMO could help the provider find ways to document the case more appropriately.

Q8: Who should be responsible for medical necessity determinations?

Capital Care: It is important to go back to the difference between determination of medically appropriate medical care and determination of medical necessity in terms of the benefits provided by the plan. The HMO defines what is medically necessary, not what is appropriate.

MAMSI: An example of this would be an employer who chose to not purchase the option of transplants. So this benefit was denied the patient, even though there was no dispute that the transplant was medically appropriate.

Question from Study Group member: Did I hear you say that, by definition, medical necessity is whatever

you stipulate in the contract the coverage is?

Capital Care: The contract has different types of benefits. A patient may need to have surgery, for example. Medical necessity would be determining whether the surgery needs to be performed on an outpatient or inpatient basis, or whether the person needs to remain hospitalized or be placed in a nursing home. The care is needed, so the question is what *level* of care is appropriate. That is how we use medical necessity determinations.

Question from Facilitator: So the determination of medical necessity should reside with the plan?

Capital Care: Yes, we define medical necessity. No benefits are provided for treatment that is not medically necessary.

Question from Facilitator: So, to push the question further, do you all agree that the determination of what is medically necessary should reside with the plan?

NYL Care Health Plans: Yes, so long as we keep the distinction between the medical decision of the treating physician and the benefit decision of the HMO, which is backed up by an appeals process that assures that the HMO decision is not arbitrary and is rooted in the medical community in which the plan operates. The ultimate recourse in all of these decisions is the standards of care of the community, as voiced by the physicians and other providers, who will ultimately decide whether utilization based on medical necessity is appropriate. We are *not* saying that HMOs should make decisions about what is appropriate medical care, and we are *not* saying that the HMOs decision about benefits is entirely in the hands of the HMO without recourse elsewhere.

Sentara: We have a contractual obligation to our employer groups to perform that function, to determine the extent of care provided under the contract that was negotiated by them.

[Everyone concurred with the facilitator's summary that there are three tiers: the tier of the physician who determines what is medically appropriate, the tier of the plan that determines the level of care that is deemed necessary contractually, and the last tier would be the appeals process that could be used in the event of a dispute.]

Quality Providers

Q9: How does the HMO address new technology and procedures? When is a procedure/ technology/ therapy deemed accepted practice and no longer experimental? What input are contracted providers permitted in this process?

Prudential: On a national basis, new procedures are reviewed in an ongoing manner. This includes getting information so that our practitioners are aware of new procedures, usually by way of a literature review that looks for peer review, double-blind clinical trials, and FDA-approval. If a procedure is determined conditionally eligible, and the last review was in 1996, I would first get information from the provider, look at the information about the individual patient, and see if the provider knows of more current literature. If we make a decision on an individual case based on new information, then I need to pass that on to the national level so it gets distributed throughout the country.

Aetna/US Healthcare: We need to abide by our oath of "First do no harm." There are as many alternative treatments as there are allopathic procedures. To make sure that we do no harm, medical decisions must done within a peer-reviewed perspective. Therefore, there must be peer review of our decisions and actions. For example, the new mammogram policies are based on data and studies that show the new technology or service is indeed effective and either enhances survival or the quality of life. That is our responsibility to our members. Secondly, we update the guidelines when there is a preponderance of evidence as supplied by oversight agencies, such as in the case of the American Cancer Society updating the guidelines for mammography.

Question from the Facilitator: Who in your agency decides that there is a preponderance of evidence?

Aetna/ US Healthcare: We have a core group that is responsible for responding to the issues, to new initiatives and technologies and policies to make sure that we are staying current. It is an ongoing process in which we are constantly reviewing procedures. On the other hand we are also trying to make sure that patients are not subject to any harm.

Q10: What are some of the economic and other incentives currently used by HMOs that may affect quality of care, either positively or negatively?

NYL Health Care Plans: Speaking in broad terms, we have a variety of mechanisms for rewarding quality care in the bulk of our contracts. For example, patient satisfaction is one measure of quality. For many of our providers this is integrated into the bonus structure or capitation build-up structure. We also reward access to care by having open panels, to increase the bonus potential, rather than having closed panels. We try to integrate this type of information into the care. If we detect a gross deviation from the norm, that would be factored into a bonus system.

Aetna/US Healthcare: Our system explicitly includes multiple monitoring, where physicians are monitored and rewarded for performance based on a number of different quality measures. We compensate accordingly, as well. We can increase their capitation based on performance according to the quality measures. All of this information is published in national journals.

Q12: How does the HMO address PCPs who appear to be high utilizers of referrals, expensive procedures, hospital-based care? What about physicians who appear to be underutilizers?

Kaiser Foundation: We have a group practice model. We identify physicians who deviate significantly by looking at their utilization, such as prescribing, or hospital utilization. The first question is whether the population that they're serving has some variation from the remainder of the group, or are they operating in an area that may be serving a different demographic group of patients within our entire service area. That usually explains the variations in the practice. If it does not, then the opportunity usually is taken to meet with the physician to educate them about how their patterns of practice in terms of utilization compare with their peers.

Prudential: We use the same process. These kinds of approaches are effective because clinical decision is grounded in three things: in science, in judgment, and habits and biases. The last area, of habits and biases, is the one that we try to address. So you can see that this might translate into a physician always prescribing a particular antibiotic, or a surgeon always wanting to keep patients in the hospital until they're eating steak as opposed to their peers who discharge the patients when they're still on full liquids. So we educate them about

how their peers are operating, and see if there are adjustments they can make without affecting the care provided to the patient.

Question from the Facilitator: Does anyone *not* follow this pattern, of first investigating the possible reasons for the deviation in practice and then talking with the physician personally?

HealthKeepers, Trigon: We follow the process, but since we are not working in a group model we don't have readily available clinical information. So we have a pattern of giving the information to the physicians up-front, showing them their peer comparison, and then having a discussion with the physicians on the high end, the low end, and those with questions. So, in the absence of clinical information like in the other model, we often have to first disseminate information with profiles and then have a discussion.

NYL Care Health Plans: When doctors are given information on how they compare, it is really useful.

HealthKeepers, Trigon: The process described applies generally to PCPs, but it is a little different for specialists, since we may not have sufficient data to generate peer comparisons and trends. Our PCP are profiled the most, about three times per year. Specialists are not profiled very frequently.

Question from the Facilitator: In a situation like this, when you've talked with the physician about how they compare with their peers, have you ever had to terminate "for cause" if they don't adjust?

MAMSI: Yes, but very rarely. We have terminated someone only once in five years, when a doctor was released for failure to adjust. This is not done lightly, and the physician is usually given two to three years to adjust. And there is lots of communication that occurs prior to termination.

Question from Study Group member: As the final step, do you let the physician know why he was terminated?

MAMSI: Yes, the letter spells it out clearly.

NYL Care Health Plans: We have never terminated a physician based on profiles. The only termination based on overutilization is a Maryland physician who was terminated because he was using procedures that were not at all indicated by the diagnostic steps that led up to those procedures. We also had the Board of Professional Quality (BPQA) at the assessment. Health plans do not terminate providers lightly, because it can be exceptionally expensive.

Study Group Representative of Virginia Association of HMOs: For clarification purposes, this kind of termination is distinct from a plan that is developing a subnetwork of specialists by an RFP process. Some doctors might consider the RFP process a kind of termination, but that is not what we're talking about here. Dr. Daniels and Tanya Denckla thanked everyone for participating in the Roundtable and sharing their views. A summary of the Roundtable session is expected to be posted by the end of May at the website address: http://**www.vdh.state.va.us**.

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Focused Roundtable for Consumers

May 23, 1997
9 a.m. - 12 noon

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the participants and explained that the Study Group on Managed Care in Virginia will be making a report on October 1, 1997. He explained that through this Focused Roundtable the Study Group wished to learn more about consumer and patient concerns and problems with managed care organizations. The group is not focusing on HMOs specifically, but all types of managed care organizations, so he invited everyone to speak to experiences with any type.

The purpose of this and the previous two Focused Roundtables has been to discuss the role of the Commonwealth in monitoring and improving the quality of care delivered in managed care organizations, including HMOs. Part of the research process is looking at the nature of complaints and grievances, and analyzing how that information might provide feedback into how the system could be improved. In the past two meetings, the Study Group has heard from HMOs and providers who told the group about how they handle complaints and grievances and how their quality improvement systems operate.

Dr. Daniels reminded the Roundtable members that the meeting would be informal. At this meeting, three broad categories were represented: (1) patients and advocacy groups, (2) complaint managers, and (3) the purchasing community. The complaint managers represented the Employee Health Benefit Program, the Center for Health Services and Consumer Protections, the Bureau of Insurance, and the Department of Health Professions. The purchasing community included large companies with protected risks and smaller employers. Dr. Daniels commended the patients for their courage and for taking time out of their schedules to share with the study group. He noted that the study group members and others may want to ask the patients questions for clarification, but that the discussions would strive to be non-invasive.

Dr. Daniels reminded the group that anything that Virginia may do in relation to HB 2785 will really only affect 25% of covered lives in Virginia. The majority of covered lives in Virginia are in plans regulated by federal laws. For instance, the majority of privately covered lives are in self-funded plans governed by the Employee Retirement Income Security Act (ERISA). He asked the group to remember that very little can be done for enrollees who are employed by large corporations with self-funded plans. ERISA pre-empts state laws regulating quality of care and consumer protection. Other health programs such as Medicare, Medicaid and CHAMPUS are also controlled primarily by the federal government.

A Study Group member added to Dr. Daniels's opening statements. She agreed that Dr. Daniels was absolutely right about the consequences of federal control, but wanted to remind everyone of the potential this group holds in terms of educating consumers. This type of benefit would not require mandatory regulations and will be a great asset to Virginia. Dr. Daniels concurred.

Dr. Daniels then introduced the Roundtable facilitator, Frank Dukes, Ph.D., from the Institute for Environmental Negotiation at UVA. Dr. Dukes welcomed all of the participants, particularly the patients. He noted that the stories would be heard in confidence and that names would not be used in the meeting summaries. He asked that members of the Study Group and other attendees respect the fact that the patients would be sharing private and sometime intensely personal stories, which should be kept confidential. As ground rules for this informal discussion, Dr. Dukes suggested that speakers be concise and remember that

we are here to learn from all participants. He noted that it was his job to make sure all of the interests were heard. Dr. Dukes also announced that one of the patients invited to speak had been in a car accident on the way to the meeting and would be arriving an hour later. He hoped that the accident was not serious. He then asked participants to identify themselves and their organizations.

Dr. Daniels introduced Dr. David Buchsbaum, Medical Director for Aetna US Health Care Virginia, who he asked to attend the meeting to answer any clinical questions related to HMO practices that may arise during the discussion. Dr. Dukes asked the observers to introduce themselves and reviewed the agenda.

Patients' Experiences

Patient #1

The speaker began by thanking the group for allowing him to represent his daughter at the meeting. His employer is enrolled in a large managed care organization. He stated that the people sitting around the table scare him because of what they may be able to do or not do for the system. The speaker passed around pictures of his daughter on the first day of her life and on her first birthday. He related how he and his wife had made the decision three days after she was born to have her disconnected from her ventilator, but she did not die.

His daughter was born with her cerebral cortex almost totally destroyed. There was no evidence of how it had happened, but doctors thought it had happened within 24-hours of her delivery. The doctors also said she would not live to one year, but she has.

The speaker stated that any doctor of neurology will testify that a child's most important developmental years are from birth to the age of three. The only reason his daughter is still alive today is because of the caring professionals at her hospital and the care he and his wife have given her 24 hours a day 7 days a week. He stated that his daughter's development will always come first to him and his wife no matter what the cost.

When his daughter was born, he and his wife had enough to worry about, without being concerned about how much the insurance would or would not cover. He had felt that since he worked for one of Virginia's top employers he and his family would be taken care of, but he was wrong. The managed care organization (MCO) refused to pay his daughter's bills for physical therapy. The speaker challenged their decision and was told that his daughter's condition was considered "developmental delay." The MCO does not cover any "developmental treatments" to any child under the age of 18 outside of any contract requirements with the speakers employer. He reminded listeners that a child's most important developmental years are from birth to age three. The MCO has refused the chance for his daughter to have a certain quality of life. He wondered what he had insurance for, if not to insure that the members of his family are given a chance at recovery and some quality of life when injury, sickness, or disease strikes. He wondered about a big business that could deny an infant the chance to be all that he or she can be, not to mention the affect that denial has on the other members of the patient's family. He and his wife have been through a tremendous amount to give his daughter what she needs and deserves as a human being.

His daughter is one year old. She is blind, she can't sit up, she can't crawl or stand, she can't kiss or hug and may never do these things without therapy. She will always require acute care. As her father, he realizes that she will never do the things we take for granted, but she can at least be given a chance to do all of the things she can possibly do. The only way to accomplish that is to require MCOs to provide assistance for a

child's development from birth to the age of three, when state and federal programs are available for developmental treatments. He feels that he has been entrusted to care for his daughter by God and implores the group to use any power they might have to help him and all of the many children and families in similar situations.

Questions and comments related to Patient #1's experience from the study group included:

Patient Advocate Foundation: There is frequently a fine line of differentiation between intervention for patients such as Patient #1's daughter based on developmental and rehabilitative services. Patient #1's daughter has fallen through the crack between those two definitions. Virginia looked at this question during the 1997 General Assembly and made the decision that cases such as the one just related needed to be addressed. Delegate Mary T. Christian introduced legislation this year to change the wording so that children age birth to three can have the services necessary for conditions that are developmental. That law has passed and goes into effect on July 1, 1997. She wanted to bring this up because it is a problem and has been recognized as such in Virginia.

Q. Consolidated Coalition for Quality Health Care: ***Is the employer's plan an ERISA Plan? And will a state regulation even apply to the case in question if it is an ERISA Plan?***

Patient Advocate Foundation: No, a state regulation will not apply to this particular case because it is an ERISA Plan, but it will set precedence on the state level for indemnity insurance. It often plays out that after legislation is passed, self-insured plans will begin to look at that issue and may follow suit.

Study Group Member: The statute that passed protects only state employees. The broader issue of coverage under private plans is being considered this year by the Mandated Benefits Commission.

Patient #2

Patient #2 opened her comments by saying that her experience is not nearly as severe as Patient #1's. In the Spring of 1994 during an annual physical, she mentioned to her primary care physician that she was experiencing dizzy spells about once or twice a month. The doctor asked her to keep a log. In June of 1994 her most significant dizzy spell caused her to black out while she was driving. Fortunately, she did not hit anything or anyone. Her primary care physician ordered a brain scan, a carotid test, and a visit with a cardiologist. She underwent several tests and wore a heart monitor for 30 days. None of the tests showed any problem.

In the Spring of 1995, she experienced a rapid heart beat on occasion. Again, no cause for the problem could be determined. A physician friend of her husband suggested that she see an electrophysiologist. She went back to her primary care physician and mentioned the suggestion. He gave her a referral, and she went to visit the electrophysiologist in October of 1995. He recommended a catheter ablation, but because of the possible side effects (a stroke) and her situation at work, she put it off.

In November of 1996, she went back to the electrophysiologist and expressed concern that the dizzy spells and the rapid heart beat might be two different problems. He ordered a monitor that could relate the 90 seconds preceding any episode. The results indicated (in layperson's terms) that the electrical impulses to her heart were getting off-track and causing both problems.

On January 6, 1997, she and her doctor scheduled the catheter ablation procedure for January 21, 1997. One week prior to the scheduled procedure, her doctor called her at home at night to tell her that her insurance company had refused to cover the procedure because they hadn't tried medication. Her doctor was upset and asked her if she minded if he appealed the decision, which she said was fine. He spoke to the doctors at the insurance company, and they reversed their decision and agreed to cover the procedure, but too late for the scheduled appointment. She was on the medication the doctor had prescribed when the procedure was canceled, and psychologically, she wasn't ready to set another date.

After having another rapid heart beat episode while on the medication, she decided to go ahead with the procedure. The procedure took place on March 21, 1997, and she has had no rapid heart beat episodes or dizzy spells since.

This problem had gone on for over three years, and though she had only blacked out once, she was very worried about it happening again. Her greatest fear was that it might happen again while she was driving and that she might injure or kill herself or someone else.

Questions and comments related to Patient #2's experiences included:

Q. Consolidated Coalition for Quality Health Care: ***How long did the appeals process take?***

Patient #2: The appeals process took about a week. Because it took so long the original procedure had to be canceled.

Patient #3

Patient #3 began by saying that since her experience took place over a number of months, she was going to leave out some of the details. On November 6, she called her HMO and complained of extreme back pain, intolerable chest pain, and shortness of breath. She called the emergency number at about 7:30 am and was barely able to speak. The operator on the phone was obviously concerned. She spoke to the supervisor, who told her to call the center near her home and make an appointment. She made an appointment for 11:00 that morning.

The doctor she saw did not take any chest x-rays, checked her heart with a stethoscope, prescribed Percoset, and sent her home. She felt much better, but she still had pain and could not sleep laying down at night.

On December 12, her right leg began to swell. Since she wasn't happy with her physician at the HMO, she went to a physician she knew who specialized in reconstructing leg injuries. The specialist was not part of the HMO plan. The specialist was certain that she had a blood clot. He immediately sent her to a hospital less than a block from his office. The physician called the HMO to ask for coverage for the surgery, and the HMO said no. They said she should go home and make an appointment with the primary care physician in the morning. The specialist refused to send her home, feeling that her life was in jeopardy. He called the primary care physician and argued with her, but she refused to approve the surgery.

The HMO decided to cover the operation but made her move to a different hospital significantly farther from her home. The specialist brought her to the radiology department, where they took a Doppler of her leg and did in fact find a blood clot. She was admitted to the hospital without the approval of her primary care

physician, but the HMO did cover the procedure. Her primary care physician did not visit her while she was in the hospital. She was attended to by a general practitioner. He was very nice and tried to explain her situation to her, though he did not know much about her condition.

On December 17, she was released from the hospital with little instruction as to how to proceed and no warning about the possible side effects the medication she was given (birth defects). It turned out that the birth control pills she was taking probably caused the blood clot, and she hadn't known about that risk either. Twelve hours after returning home, she started having pains in her right leg again. She called the general practitioner, who did not have any explanation, so she called the specialist. The specialist recommended that she see a hematologist.

The HMO would not cover a trip to the hematologist, but she decided it was important and went anyway. The hematologist did blood work and asked her to go home until he got the results. In the evening, he called with the results, and something was wrong. The hematologist told her to go to the hospital immediately because the blood clot was probably propagating. She called the general practitioner, who was baffled by the situation but approved her admission to the hospital. She called her original primary care physician, who once again told her she would not approve her admission to the hospital. Patient #3 told the primary care physician that she was going to the hospital anyway.

At the hospital, the hematologist spent two hours trying to find someone at the HMO who would approve Patient #3's admission to the hospital. They finally approved her admission, and the technicians performed another Doppler. The blood clot had propagated, and they detected two more.

Patient #3 feels that not being admitted to a hospital, or any hospital, was absurd. She realizes now that she probably should have just gone to the emergency room because it would have been harder for the HMO to refuse coverage. On two separate occasions, Patient #3 was told her care would not be covered in hospitals that were, in fact, listed in the organization's book.

While in the hospital, she made a formal oral complaint about her primary care physician, saying that she thought the physician had made some poor decisions. The HMO was supposed to follow up on the complaints, but no one ever contacted Patient #3. She decided to make a formal written complaint. She went through the official procedure and attended a meeting at which she explained the experience. The people at the meeting agreed that her admittance to the hospital should not have been delayed and that she had been treated poorly, but the formal written response stated that nothing had been done wrong and that they would not take any action.

She decided to contact the Insurance Commissioner's Office. After speaking to state representatives in several different departments she found that the Commonwealth really doesn't have any power to regulate or reprimand HMOs when they make poor decisions or regulate or reprimand physicians who are part of HMOs when they make poor decisions.

Patient #3 feels lucky to be alive today and believes that she is here only because the specialist looked after her. She feels that the HMO must have offered some kind of financial incentive to the primary care physician that lead her to refuse the patient's admittance to the hospital. She couldn't believe that the doctor would refuse her admittance even with test results indicating that she had a blood clot.

Questions and comments related to Patient #3's experience included:

Q. Rash & Associates: ***If the original primary care physician was an employee of the HMO, what was the HMO's policy on switching primary care physicians? Why couldn't you switch?***

Patient #3: The physician was an employee of the HMO and was not private practice. The HMO allows patients to switch their primary care physician at the first of the month. I had selected a different primary care physician, but I never saw the new one.

Q. Rash & Associates: ***What reason did the HMO give for why you could not be admitted to two hospitals that were listed in the HMO's publication?***

Patient #3: The HMO never responded to that question in either my verbal question or written complaint.

Q. Study Group Member: ***Should the complaint about the physician have been made to the Virginia Department of Health Professions? And how would it have been handled?***

Virginia Department of Health Professions #1: Yes, the complaint about the physician could have been made to VDHP. The complaint intake analyst would have reviewed it. Then they would go to the complainant and make a decision whether the case should be investigated. The case would be referred to the Board of Medicine, where they would decide whether the physician was practicing below the standard of care. This procedure would deal with the general behavior of the primary care physician, but not necessarily the care the specific patient was receiving.

Q. Virginia Health Quality Center: ***Were you (Patient #3) advised to talk to the Board of Medicine concerning this specific physician?***

Patient #3: No, my contact with the state was a little confusing. I didn't really know where to go.

Virginia Department of Health Professions #1: We would have referred that matter to the Bureau of Insurance.

Virginia Department of Health Professions #2: There are so many things involved in this type of issue, one of which is the decision-making of the primary care physician and the contact between the physician and the patient. Another issue is the question of the coverage and how it effects the relationship between them. This case is one we definitely would have looked at through our complaint process, though the outcome in this case can not be predicted. Our office can deal with the doctor, but not with the HMO.

Q. Consolidated Coalition for Quality Care: ***Does the State of Virginia have laws for a prudent lay person definition of emergency services?***

General group: Yes.

Q. Consolidated Coalition for Quality Care: ***Does Virginia have laws stipulating that individual members of an HMO should have their choice of a primary care physician and can switch?***

Study Group Member: I believe there is statutory language, but I will have to check.

Q. Consolidated Coalition for Quality Care: ***Does Virginia have statutory language that states that individual enrollees can see at least a summary of the contract between the physician and the HMO to understand what the incentives are for their primary care physician?***

Study Group Member: No. By statute, the information is available to the purchaser of the plan, meaning the employer of the enrollee.

Consolidated Coalition for Quality Care: This is a very enlightening case that brings out a lot of issues. It can inform how the state might respond. All of the stories are very enlightening.

Q. Virginia Health Quality Center #2: ***How did the Bureau of Insurance handle your (Patient #3) concern?***

Patient #3: I believe the case has been closed. I contacted them on a number of occasions. The last communication implied that there was nothing more they could do, but I might be wrong.

Q. Consolidated Coalition for Quality Care: ***How did the plan respond to your (Patient #3) formal complaints?***

Patient #3: The HMO did not respond in any meaningful way. I received responses, but they never responded to the complaint about the primary care physician directly. They said they had investigated, that they were interested and concerned, but they had not found anything wrong. They did allow me to chose a new primary care physician.

VDH, Center for Health Care Services and Consumer Protection #1: Patient #3's complaints were referred to our office to investigation of health care quality issues. We also corresponded with the HMO and got no specific response. The last communication we received from the HMO stated that they had taken "appropriate action", but when we asked them what "appropriate action" meant, they repeated the statement with no explanation. This case is still open; we are still pursuing it.

Q. Virginia Department of Health, Staff: ***There are required reports that health plans or hospitals make about their health care providers. Would this have applied here?***

Virginia Department of Health Professions #1: Any licensed health care provider can have our complaint toll-free number. It is on the license of every practitioner, in the blue pages of the phone book, etc. There is required reporting of some health care instances in the state, basically when a loss of privileges has resulted. If the Commissioner of Health or other official has knowledge that some one is practicing in violation of the laws covering the practice, that must be reported to us.

Patient #4

Patient #4 explained that her story is rather lengthy and passed around a written summary of events. In

1995, Patient #4 was in two different car accidents. In May of 1995, she was hit from behind when she slowed to avoid another car. She was insured through her employer with HMO A. She had to fight with HMO A to get her bills paid throughout her treatment. The HMO did not acknowledge her bills until an attorney got on the phone and discussed it heatedly with them. Because of this experience, Patient #4's employer decided to switch to another plan. The change was scheduled for December of 1995.

In November of 1995, only seven days before treatment for the first accident was to be completed, she was involved in another accident. She was again hit from behind. She knew she was going to be hit, and she braced herself with her hands on the steering wheel to keep from injuring her neck and shoulders. Bracing herself injured her hands and elbow.

The second accident occurred only nine days before her employer was going to switch from HMO A to HMO B. The people in her company were now worried because she would need treatment, and her injuries would be considered a pre-existing condition. The sales representative from HMO B said there would be no problem. They also asked if the doctors who were currently treating her would be covered. They asked these questions numerous times and were always told that there would be no problem.

Since then, she has had nothing but trouble with HMO B. Her doctor, who started the treatment in December told her that he would have to perform surgery to fix her injury, and they scheduled the procedure for February. It turned out that the orthopedic center at which she was being cared for was going to drop from HMO B's list of care providers. The center assured her that they had made arrangements for her surgery to be covered, and she continued treatment.

The surgery was performed, but one of her hands did not respond as well to treatment as they had wished. Her doctor felt that further surgery for carpal tunnel syndrome was needed. Patient #4 approached HMO B asking whether she could continue with this doctor since she had already been through so much. Representatives at HMO B said she would have to appeal because the doctor was no longer part of the plan. They said the appeal process would take about two weeks.

The appeal process stretched to take over two months and ended in HMO B's denial of coverage. They finally gave approval after Patient #4 faxed all of her notes showing that she had done exactly what she was supposed to do (she had worked for an attorney and had learned to take good notes). She had followed every requirement properly. They called her at night saying that they had news for her and that they would call her in the morning. They did, and they approved her doctor for the surgery.

Finally, the doctor was able to take x-rays of her hand only to find out that in addition to the carpal tunnel, there was a problem with her joint. She and her doctor anticipated that there would be a problem with HMO B, but they asked for coverage anyway. To her knowledge, HMO B has never responded to that request.

She was tired of waiting and went to another doctor who was part of the plan. Patient #4 stated that if she had known that it would take 2 or 3 months to receive an answer to the appeal, she wouldn't have waited. Her injury was getting worse during the time that she was waiting and needed to be addressed. Over the past year she has had four surgeries; each time there has been a problem with HMO B and getting procedures approved.

Patient #4 is most annoyed by the fact that she tried to follow the procedures and tried to do everything

they asked her to do. They told her it would be easy to go through the process, but it wasn't. She has been screamed at by a representative from the HMO, who told her that she was creating the problem and that she should never had chosen a doctor who was outside of the plan. However, when she chose her doctor he was part of the plan and had no reason to believe that he would leave the plan. That decision wasn't made until her treatment was well underway.

HMOs do not treat you the way they say they are going to, and Patient #4 questions some of the rules HMOs require enrollees to follow. The last time she was in the hospital, she struggled with the HMO. She needed a wheel chair, and her doctor called to get one through the HMO. She was supposed to leave around 10 a.m., but they came and told her that they could not get a wheel chair for her until 4 or 5 p.m. She asked why. They just repeated that they couldn't get one. Then she and representatives from the hospital started calling the HMO to get it straightened out. At one point a representative from the HMO told her that someone was speaking to the caseworker, but the case worker was in her room and wasn't speaking to anyone at the HMO.

They finally found out that the wheel chair the HMO had ordered for her was being transported from a city in a completely different part of Virginia. She asked the HMO if they were going to pay for the additional time she would be in the hospital because the hospital would not release her without a wheel chair. They said that she would have to pay for it. She told them she would not pay for the extra time, that they would have to, and they finally got a wheel chair to her within about an hour and a half. The wheel chair came from a company that was much nearer to her hospital. She wonders why they did not do that in the first place.

Patient #4 also questions the process for approvals for payments for treatments. She needed a special kind of brace for her arm. If the brace can be purchased in a health supply store, the insurance does not cover the cost. If the brace is custom made, then the cost may be covered. When they were getting ready to put the brace on her hand, the insurance specialist from her orthopedic center called the HMO and was told that the cost would not be covered. The same day, the specialist called back again and was told that the cost would be covered. Patient #4 feels that the two representatives, sitting side by side, were looking in different manuals. The same question was asked to two different people; one looked in one manual the other looked in a different manual, and they arrived at different answers. Patient #4 questions the credibility of the HMO. The brace was $60. She paid a $15 co-pay. The HMO paid $5. Her doctor paid the rest. She wonders how long her doctor can afford to continue as part of the HMO. The $20 he received did not even cover the cost of materials.

Questions and comments related to Patient #4's experience included:

Q. Study Group Member: ***What role did your employer play during this time?***

Patient #4: My employer mostly wanted me to be at work as an effective employee. Through the surgery they were supportive. They let me use the fax machine to communicate with the HMO, and they gave me time to come to this Roundtable. My employer tried to change insurance companies again this year when they were informed that the enrollees would have to pay twice as much for coverage.

Q. Rash & Associates: ***How many employees are in your company?***

Patient #4: There are nine at my location, and there are several other locations with a similar number of employees.

Q. Consolidated Coalition for Quality Health Care: ***Are there any statutory provisions in Virginia, as there are in other states, for the continuation of provider relationships when employers change HMO plans?***

Study Group Member: In Virginia, the statute allows continuation of provider relationships for 60 days after the notice of termination, not until the end of the episode of care.

Consolidated Coalition for Quality Health Care: Maybe the law should say it should extend through the episode of care, instead of an arbitrary date.

Study Group Member: That was proposed at one time, but we ended up with 60 days.

Study Group Member: Most HMOs have guidelines for continuing care on a case by case basis.

Q. Rash & Associates: ***Isn't continuation of provider-patient relationships treated differently by different HMOs?***

General Group: Yes.

Q. Patient #1: ***As a consumer I have a real concern because my daughter has cerebral palsy that was diagnosed at birth. If my employer decides to change plans, do I only have 60 days to find a doctor who will take on my daughter as a patient for a pre-existing condition that is usually excluded from these programs anyway?***

Rash & Associates: The major problem would be that if they switched to a different HMO, there might not be a provider within the network that could render the appropriate care for your daughter. Pre-existing conditions are not the issue here. It is a question of finding someone who could continue the care and someone with whom you are comfortable continuing care.

Q. AARP: ***Are the guidelines for continued care uniform or are they determined by the HMO?***

Study Group Member: The statute speaks to the time of notice. Beyond that point each HMO can deal with the process differently on a case by case basis.

Q. VDH, Center for Quality Health Care Services and Consumer Protection #2: ***Does this include obstetrical care also, such as someone who was six months pregnant?***

Study Group Member: I do not know whether the statute speaks to that, but I know of no plan that has ever

forced a pregnant patient to change obstetricians under the circumstances of the employer changing plans or the provider leaving the plan. If the provider leaves the state, that is a different question.

Rash & Associates: That is usually accommodated.

Patient #5

Patient #5 opened by mentioning that she feels just fine despite her car accident earlier that morning. She stated that today she would represent the Virginia Mental Health Consumers Association which protects the rights, dignity, and quality of care related to mental illness. In her professional life, she is a health care professional, but she is also a consumer of both mental health and other care services. Through her work and personal life, she is able to see many issues in the mental health care field.

Her first concern is what the previous conversation revolved around: access to appropriate choices. Persons with chronic illnesses, whether it is mental, something like diabetes, or anything that requires a specialist, are faced with some difficult decisions when they are choosing an insurance plan. The enrollee must choose between a primary care physician who coordinates all of their other care and the person who has been following them for a long time for episodic or chronic conditions. Often those doctors will be in the plan, but in many cases they are not. Many people are faced with the question of whether they can go outside of their plan's network. Often the answer from plans is that they can not go to a doctor who is outside of their plan network, so they take their chronic history to someone who has never treated them before.

Another question related to the choice of a plan is the availability of certain medications. When consumers ask these types of questions, they are often answered by the marketing people or sometimes the customer service representatives. Usually, the representatives try to answer the question well, but often they can only tell the enrollee that a certain medication is available now but can't be guaranteed later. It is very important for people with chronic conditions to have more consistent information for their decision making. For those people who are healthy and rarely need to see a doctor, decision-making depends on cost and convenience. This is not the case for those with chronic conditions, and for them, the amount of information available to an applicant is a concern.

People are asking what the complaint process is, and they are not being given an understandable answer. They ask for it in writing, and it is not forthcoming. This is a problem.

For psychiatric care, and for other conditions as well, new medications are coming out all the time. These medications offer hope for recovery, but also offer a chance for HMO's to reduce their costs because these medications reduce the need for other kinds of services. Sometimes the new medications are not made part of the HMO in a timely way. This is confusing to the consumers, who may not be aware that the medication is out on the market. The doctors in the plans do know. Patient #5's organization has found that doctors in plans often are not permitted to tell consumers about new medications that are out on the market. When her organization is made aware of the new medications, they try to let consumers know and try to help them get access to the new medications.

Another issue is waiting time. Her organization has heard a number of complaints that the patient can get an appointment within a day or two, but must wait in the doctors office for a long time and take time off from work. They often have to wait for two or three hours. Often their physician was not enrolled in the HMO plan and joined later. Before the doctor joined the HMO, the waiting time was significantly shorter. The

person who knows that they will have to take two or three hours off from work and does not have the type of job that affords them that luxury is frustrated by sitting in a doctors office and losing wages. Often, they do not return for care and that ultimately worsens conditions.

Providers have played a critical role in reducing the number of complaints. One of the things we have heard consistently from members of the General Assembly, HMO Management, and from other advocacy organizations is that there is just not a consistent record of complaints showing a problem. One of the things we have done very poorly is tracking complaints. Often a patient may go in to see a primary care physician or a specialist and have some barrier to getting service, but often the provider has taken on the burden of making sure the patient gets the care s/he needs. The doctor may not tell the patient that s/he is going to put in a special request to an HMO for a medication that is not readily available to the general, enrolled constituency. The patient may never know that someone has requested on his/her behalf and been denied.

Complaints are often ambiguous. People will call customer service with questions about the care they are or are not receiving, but they never put it in a formal complaint form. As customers, we contribute to the fact that complaints are not collected for all of the different issues.

There is a disconnect in the appeals process. The biggest problem is that consumers do not know how to navigate the system to appeal. It is very confusing and requires a high level of skill.

Out-of-network providers are another issue. Patient #5 recalled one case in which a potential enrollee asked the HMO whether an individual who was the HMO's medical director, but not listed as an approved provider, could be considered a provider under that plan. The consumer was seeing that doctor, who worked for the plan choosing "Best Practices" and performing other tasks, but was not allowed to continue seeing him. Patient #5 is not sure how this barrier can be relieved to allow patients to stay with their doctors while abiding by the network's rules and regulations.

In mental health, HMOs normally offer 20 out-patient visits. Patients often complain that they can easily get one or two appointments, but that it is very difficult to actually have all 20 visits. Patients with serious disorders, such as schizophrenia, bi-polar disorder, depression, find it very difficult to complain. Unless they have a family member or someone within the provider network who will look out for them, they really do not have an advocate. There really is a need for an ombudsman service or someone else accessible to everyone.

This is a general list of some of the concerns. The last one is utilization review. Patient #5 described utilization review as an IRS audit. HMO representatives review the documented medical history of a patient, and by what is documented, they determine what type of care the patient is going to receive. Often utilization review is so external from a patient that simply brief contact with the patient and provider by the reviewer could improve the process, avoid denial of care, and ultimately, avoid the appeals process. Often, significant information is missing from the documentation. Patient #5 recalled an example that involved a psychiatric care patient who had been able to avoid in-patient care. The utilization review resulted in the denial of out-patient care, despite a 10 year history of responding well to out-patient care. The doctor said that in-patient care was unnecessary and that the patient had been maintained in an out-patient setting with intensive treatment. Unfortunately, the records did not document that clearly to the HMO, and the HMO ended up paying for a week of in-patient care that was wholly unnecessary. That is an extreme example, because often we hear stories that HMOs are not offering enough care, but it highlights the need for greater communication during utilization review. The interaction between the utilization review person, the doctor, and the patient needs to be more connected. The review is not an external function, and it should be done by a professional.

Best Practice guidelines are created by an HMO by looking at a specific condition and determining what the best course of treatment is for people who are in a diagnostically related group. It may be psychiatric or something like diabetes. The plan decides what the Best Practices are. Often other practices are not common knowledge to the patients. There are many treatments that come out that are not experimental that do not fall within the HMO's Best Practices. The patient may be with one HMO that uses one type of medication but change to another one with different set of Best Practices, possibly because one is less expensive. The second HMO might not allow the patient to continue using the same type of medication or treatment. Patient #5 wonders if there can be universal Best Practice Guidelines. This is a big challenge; we can't even get a national speed limit!

To summarize, the issues are:

enrollment access to information about the services available

complaint process and how to network with the providers

access to new medications

waiting time

switching primary care physician (especially with psychiatrists)

utilization review

Best Practices Guidelines

Discussion of Questions for Consumers

Facilitator Dr. Dukes opened the second part of the Focused Roundtable for Consumers by repeating the ground rules and inviting everyone to speak to the questions printed on the agenda. The questions were the following:

Please identify the most typical quality of care concerns that enrollees have about the quality of care provided by HMOs. Here are some categories of examples:

Access to care

Denial of care

The quality of providers

Pharmaceutical formulary

Timeliness of preauthorizations

Criteria for experimental care

Limitations of hospital length of stays, access to outpatient services

Are HMO enrollees provided with the kind of information that allows them to successfully understand and access HMO's complaint/grievance/appeals systems?

What have purchasers and consumer advocacy groups done to inform patients and consumers of existing appeal and complaint mechanisms?

How frequently do HMO enrollees access state regulatory complaint systems, and is the information they receive helpful? How could it be improved?

Is the state oversight authority sufficient to ensure that the complaints of individuals affected by the delivery of services within the HMOs will be adequately addressed? What needs to be done to ensure that it is adequate?

The facilitator opened the discussion by asking that all three categories of invited participants (patients and advocates, plan purchasers, and complaint managers) address the first question. He asked that people discuss the issues brought up by the first question, whether the examples cited made sense, if there are others that should be added, and any experiences that may illustrate their comments.

Quality of Care Concerns

Patient Advocate Foundation #1: While we handle patient calls from all 50 states, I have tried to tailor my remarks to Virginia. Quality of care becomes an issue when a patient is being redirected. If the redirection takes place before the patient is admitted to the hospital, then perhaps the redirection is beneficial to both the consumer and the HMO, given the need to manage medical costs in this country. However, the two instances we bring to the Committee today are of patients who were hospitalized in Northern Virginia and insured by an HMO in Northern Virginia. While hospitalized, they were informed that they were going to have to be moved to another institution. In both cases, the physicians treating the patients protested the move of these patients from one hospital to another. In one instance the patient was going to be redirected to a hospital that was several hours away. This particular patient was in a very critical condition at that time. The patients were moved. The 35-year old gentleman who was the sickest of the two patients, died within four hours of his arrival at the second hospital. That is a quality of care issue that concerns us. If a patient needs to be redirected for care, our recommendation is that the redirection come before the point of hospitalization and that the patient and the treating physician have an opportunity to discuss it. The specifics of that case have been provided to the Study Group.

Study Group Member: I would like to make one comment about that, and I may stand to be corrected. In the State of Virginia, an HMO, unless it is the direct provider of care, is not subject to any type of medical malpractice. A consumer has very little chance of pursuing that through the legal system, unless you were to sue on the basis of a violation of the contract, which is a much more limited right. You cannot go to the legal system to complain about the HMO's decision in requiring a move that resulted in somebody's death.

Study Group Member: (to Patient Advocate Foundation #1) I assume that you are not suggesting that transfer to another facility is, in and of itself, an inappropriate judgment, for medical reasons.

Patient Advocate Foundation #1: We are saying that if there is a decision to move a patient that it should be done with the full support of the treating physician and, hopefully, with the full support of the patient. In these cases, the treating physician urged the HMO not to move these patients.

Rash & Associates: What reason was given for the patients' redirection?

Patient Advocate Foundation #1: It was a financial reason. The HMO notified the hospitals where the patients were staying that they would no longer pay for any coverage for any care given to them while in that

institution. The institutions were part of the HMO network, and both patients had been admitted to facilities that were part of the approved plan for the HMO. Both of these cases were long term hospitalizations, and they were being moved to a different level of care.

VA Health Quality Center #1: The Virginia Health Quality Center is federally designated and a major part of their work revolves around analyzing quality of care for Medicare. However, we have also looked at these issues for Medicaid, Champus, and other review categories. One of our major responsibilities has been to review specific instances of care given to these types of patients, but more recently we have been looking at broad patterns of care, addressing important issues of quality of care, and trying to improve care. Specific instances regarding (1) the discharge of patients have come to our attention over and over through a contract with Medicaid. Often patients are worried that they are being discharged from the hospital too soon and without comprehensive instructions for follow-up care. More recently, there are rising numbers of complaints in the area of (2) nursing homes. These concerns relate to questions of whether they need a more skilled type of care or whether patients are being referred in a timely way for acute care. There are always complaints regarding (3) specific physicians and hospitals. As you know, the number of patients enrolled in Medicare HMOs is small at this time. We are the people who would review those complaints, independent of the HMO, hospital, or provider. We function as advocates for the patient.

There are other more specific issues that have been mentioned under broader categories, such as whether patients are afforded options of care for the early stages of breast cancer (breast conservancy therapy vs. mastectomy), appropriateness of the use of cardiac catheterization, and others. We are also conducting on-going studies about the use of anti-coagulant management of human strombosis, peptic ulcer disease, flu immunizations, access to mammography. One project geared directly towards HMOs is looking at the treatment of diabetes and whether patients are having the types of tests they need.

Virginia Department of Health (VDH), Center for Quality Care Services and Consumer Protection #1: To date we have had 32 complaints referred to us from the Bureau of Insurance dealing with HMOs. The largest group of complaints concerns access, in terms of denial of referrals or urgent care. The next largest has to do with provider care. The third group is concerned with pre-authorization, continuity of care, slow response to urgent situations, lack of action on complaints. Examples:

> An enrollee diagnosed with an aggressive form of brain cancer was told that this type of tumor could double in size over the course of ten days. The in-network oncologist suggested that he see a doctor who specialized in the growth of tumors, and he was offered a random, computer-chosen treatment. Two different types of treatment were not effective. Through the advice of the oncologist, he found an experimental chemotherapy program at an university hospital. The physician at the university did a craniotomy, and a drug company supplied the experimental chemotherapy at no cost. The HMO denied coverage because the university was not an in-network provider, even though it became one while the enrollee was receiving treatment. The university and the physician both agreed to accept the HMO's usual payment, and still the HMO denied coverage. The enrollee wrote to every known public representative and state agency. Eventually, the HMO did agree to cover the treatment, but the patient went three weeks with no treatment option.
>
> A five month old developmentally delayed baby was referred for treatment of gastro-esophageal reflux. The referral was delayed from February 25 to April 16 before it was approved, a significant amount of time in this child's life. The enrollees complained to their public

representative who passed this information to the Center. Blood work for ill children had been delayed at the laboratory because the HMO would not pay for it at the pediatrician's office. The plan requires children to go to an in-network hospital to have the tests. The public representative had received 7 complaints of this type in the last month. This delays treatment for the children.

Another enrollee had surgery delayed because of a lack of surgeons to do the orthopedic procedure. The enrollee was told the surgeons were all on vacation.

An applicant who had been raped in 1989 sought counseling for that episode in 1995. She was denied the opportunity to enroll in an HMO in 1996. She felt she had been a victim twice, because she was doing the appropriate thing to maintain her mental health.

An enrollee complained that an HMO physician diagnosed herpes zoster (shingles) as acne. The HMO took no action about that complaint.

Several enrollees have complained because the HMO does not respond appropriately to emergency situations.

Several enrollees complained that HMOs do not cover breast reconstruction, but instead offer prostheses. This is of great concern to the patients, particularly in relation to their mental health.

A provider complained that the HMO would not cover any laparoscopy or hysteroscopy that he performed because the HMO utilization review had determined that the procedures had been used inappropriately on two other enrollees.

Complaint Process

Study Group Member: (to VDH, Center for Quality Health Care Services and Consumer Protection) What do you do when you get these complaints?

VDH, Center for Quality Health Services and Consumer Protection #1: We talk to the complainant and provider to get all of the details and urge the patient to go through their HMO's grievance process. Then we write to the HMO and ask if they have an explanation. We try to get information from all of the parties involved.

Study Group Member: How many employees do you have investigating these claims?

VDH, Center for Quality Health Services and Consumer Protection: We have one new employee who will be devoted solely to this. We have a total of 6 employees who deal with these claims.

Study Group Member: Over what time period did you receive these complaints?

VDH, Center for Quality Health Services and Consumer Protection: The majority of complaints have come in the last 2-3 months. We've been tracking them for the past year.

Study Group Member: What have you done to ensure confidentiality? When you pass that complaint along to an HMO, have you used a waiver form from the complainant to discuss that particular case?

VDH, Center for Quality Health Services and Consumer Protection #1: We do speak to the complainant in every single instance, if we are able to reach them.

Study Group Member: That piece of the process is critical. If an HMO were to get a notice from you, and

you did not advise the HMO that you had a waiver regarding confidentiality, that could delay the process.

VDH, Center for Quality Health Services and Consumer Protection #1: We also accept anonymous complaints.

Study Group Member: That's fine, but if you want some resolution to the case...

Study Group Member: There is a new confidentiality waiver form for patients from the Health Department.

Study Group Member: I believe the Medical Society sent out a form to all of the physicians. It was from the Bureau and the Housing Department. They asked that it be placed in the physicians' offices so that patients could get them and file complaints.

Complaint Remedy

Study Group Member: What is the remedy when the Health Department has found a problem in the quality of health care? What do you do?

VDH, Center for Quality Health Services and Consumer Protection #2: Right now, the Department of Health does not have its own regulations. We are currently functioning under the State Corporation Commission. If there should be a remedy, the Department of Health would recommend it to the State Corporation Commission and the Bureau of Insurance. They can impose penalties.

Study Group Member: Part of what we are doing in the context of HB 2785 would be considering whether additional regulations are needed.

Study Group Member: Of the 32 complaints that you have received, have any been referred to the Bureau of Insurance?

VDH, Center for Quality Health Services and Consumer Protection #1: Many of them were referred to us from the Bureau of Insurance.

Study Group Member: Have you sent any of them back to see if any action should be taken?

VDH, Center for Quality Health Services and Consumer Protection #1: We have copied many of them and sent them back, but that resolution is not always satisfactory to any of the parties involved.

Study Group Member: (to the Bureau of Insurance) Once you get them, what do you do?

Bureau of Insurance: As far as I know, if there has been an quality of care issue, the statute does not give us any authority to impose penalties.

Study Group Member: There are different points in the process that different departments can receive complaints, but ultimately, they make it to the Center for Quality Health Services. Once it has been to the Bureau of Insurance, then the Virginia Department of Health will look at it. If it is a provider complaint it should be referred to the Department of Health Professions. We have to look at that process, and whether it is consumer friendly. If a complaint came to the Department of Health Professions that was not a complaint directly against a physician, the SCC - Bureau of Insurance would make a referral to the Center for Quality Health Services. After all of that has happened, you have a resolution. The next question is, is there a log that is kept? Is there some way that this loop knows that the loop has been closed?

Department of Health #1: There is a log kept at the Center for Quality Health Services and Consumer Protection, and the Bureau of Insurance has a fairly sophisticated data bank with contract issues. At the end, the complaint will go into the HMO's file. At the time of the Market Conduct Survey, that would be one of the quality indicators we would look at. We would look to see if there is some trend or problem with the system.

VA Health Quality Center #2: We are here to figure out this process for the State, but it might help to hear what we do at the Virginia Health Quality Center. As a federal contractor for the Health Care Financing Administration, we follow a process whereby we can make a recommendation to the Secretary of Health and Human Services that a facility, physician, or other type of provider be removed from the Medicare program. This has a significant impact on an individual's practice. On a less drastic scale, we can require that physicians or providers do educational work, ranging from attending courses to being overseen when completing certain tasks to engaging in fellowships or preceptorships under experienced physicians. We profile these facilities and physicians over time so we can see if these complaints continue to occur. If the pattern continues, then we can sanction the facility or provider. VA Health Quality representative #1 is more involved in this, so she can add to what I am saying.

VA Health Quality Center #1: Our sanction authority allows us to recommend to the Secretary of Health and Human Services that a physician be excluded after a very comprehensive review process that includes an appeals level with a panel of physicians and other health care providers who meet with the provider. We discuss the nature and root of the problem thoroughly, as well as what could be corrected so that it will not happen again. In that process, we address correct actions or improvement plans. We look at whether there could be a change of protocol at the level of the provider or facility or whether the problem requires a remedial response, such as education or retraining on a certain procedure. There is a broad range of intermediary actions that we take with providers to make sure that this type of problem does not happen again.

Rash & Associates: Can you explain what a Market Conduct Study is? I hear that term a lot from the insurance companies. Are you looking at the marketing material, such as things that are misleading? Or are you looking at the quality issues?

Bureau of Insurance: The Market Conduct Study looks at anything the laws govern. That includes the marketing information and claim payments. We do not have medical people, so we cannot look at quality of care issues.

VDH, Center for Quality Health Care Services and Consumer Protection #2: That is the purpose of MOU with the Department of Health. We physically go with the Bureau of Insurance during their Market Conduct Surveys and look at quality issues such as access, availability, provider credentials, the Quality Assurance Plan, what kind of services they are providing, quality of providers, and all of the complaints that the plan has received.

Study Group Member: As part of this study, we are trying to describe the complaint and grievance process. We have written a document that is currently being reviewed by the different agencies that discusses the statutory and regulatory details. Maybe we should make a simple flow chart for a complaint as it goes from beginning to end, so we can get the big picture.

Study Group Member: I just wanted to comment on the subject of remedies for complaints. VDH, Center

for Quality Health Care Services and Consumer Protection #2 has pointed out that through the Market Conduct Surveys, which the Commissioner had the authority to do before the statutory change but elected not to, one of the remedies is monetary sanction or fines for the HMO. Other remedies through statute are found in the HMO Statute itself, which speaks to the revocation or suspension of licenses based on a finding by the Commissioner of Health. There are about seven or eight different types of findings, which are all related to the issue of quality of care, access, and failure to insure benefits for the enrollee. You have the possibility for monetary fines through the Market Conduct Survey as well as statutory authority for suspension or revocation of the license.

VDH, Center for Quality Health Care Services and Consumer Protection #1: I just want to be clear that we have 23 categories that we certify for the federal government. When we find that there is a problem with a provider or hospital our files are open to the public.

AARP: As this conversation has bounced around from this Bureau of That to the other, think of the poor consumer on the street. On a different subject, I have traveled around the Commonwealth and the country on behalf of AARP. I think all Medicare programs should be held to the same regulations that all HMOs are held to. From an access point of view, the issue is choice. Do I have a choice about HMO, about providers, etc.? There is also a big concern about pharmacy formularies. The Secretary of Health and Human Resources has a study on anti-drug switching. Yesterday's *Wall Street Journal* had an article about HMOs. The point is that there is a perception of problems with HMOs. This may never reach the actual formal complaint process. Whatever comes out of this study is going to have to be salable to the general public so that they can have confidence in the system.

Facilitator Dr. Dukes asked the group to consider questions two and three. He asked that the patients and advocates speak first.

> *2. Are HMO enrollees provided with the kind of information that allows them to successfully understand and access HMO's complaint/grievance/appeals systems?*
>
> *3. What have purchasers and consumer advocacy groups done to inform patients and consumers of existing appeal and complaint mechanisms?*

Consumer Use of the Complaint Process

Consolidated Coalition for Quality Health Care: The comment made by AARP indicates that consumers' concerns go beyond the grievance and appeals process. In fact, we should look at these grievances and appeals as testimony to the failure of our health care system. We should be dealing with this from a regulatory point of view, through licensing standards, and a monitoring program, information for consumers. We need to build a kind of delivery system, which is the aim of all of us here, that preempts these kinds of complaints. The discussion today deals almost entirely with the grievance process, yet I think the Study Group is entitled to make recommendations about licensing standards, the need for on-going quality monitoring, and the need for detailed information for consumers so they can navigate the system.

It is foolish to believe that the only time a consumer has an interest in the health care system is when they have a serious complaint. In fact, there will be very few serious complaints about this, and yet there is lots of confusion and concern about it. What you are hearing from the advocates sitting around the table is that we do have to work on the process for grievance and appeals, but we also have to work on licensing standards and a monitoring system that works on a population basis to ensure that the HMO is referring people appropriately to specialists, is admitting people to hospitals when they should, etc. That's not something that individuals can monitor. I hope today or at some future point, we can expand the discussion to the full range of quality protections and quality accountability systems that are needed. I do think that this issue extends beyond the grievance and appeals subject.

Study Group Member: I understand what you are saying, but a couple of points are necessary to understand as well. The study was only given five months. What you've outlined, when we were in the Federal Government would have been a 2 year, $2 million Rand Corporation Study. Secondly, right now, on-site examinations are taking place at HMOs. Perhaps we should look at more frequent examinations. Right now, if nothing were to change there are about 6 HMOs per year visited to review their quality of care plans. This process of on-site examinations should hopefully identify some of the problems you are discussing. We are gathering information so we can look at this in an impartial and objective way.

Consolidated Coalition for Quality Health Care: I understand that. We also need to look at what is actually on the books, like the standards that are used by Conduct Market Surveys, to make sure that appropriate standards exist. A lot of issues came up this morning about whether there are appropriate expectations for plans on such issues as continuation of provider services when there is a termination of the plan, a standing referral to a specialist when an individual has a chronic condition, appropriate marketing guidelines to make sure that enrollees understand exactly what their rights are when they enroll and know the incentive structure of the plan for the individual doctor, that they have a choice of a primary care physician, and that the patient can go to an emergency room when he/she believes that their health is in danger. Part of the evaluation has to be not only the substance of the market survey, but also an evaluation of whether the appropriate statutory expectations and standards are in place so that the licensing oversight can be appropriate, so we can build in quality and consumer protection and never get to the point in time when we are sitting around the table talking about consumer complaints and appeals. That is a failure of the system. We need to build protection in.

Rash & Associates: Typically the information that enrollees get from the plans is what is called an "Evidence of Coverage Book." In that booklet, the grievance procedure is outlined, but that is only for the plan that they are enrolled in. Many times people are completely unaware of other opportunities for assistance through the Bureau of Insurance or the Department of Health or even through advocates. It is very easy for the process to disconnect because there are so many threads. The issues involve the patient (employee and member of family), the employers, the providers, the insurance company, marketing, finance, attorneys. It is very confusing and very easy to get disconnected.

Consumer Information and Education

Patient Advocate Foundation #1: (endorses Consolidated Coalition for Quality Health Care remarks) The HMO industry is requiring the consumer to become an informed and responsible consumer. However, today you have heard cases of patients who have become informed and have tried to work within the system and follow the rules. You have heard about people such as Patient #1, who have been fighting this battle for over a year. If there is anything you can do to improve the system for the industry and the consumer, it should be

that the documents received by enrollees include all of the information they are going to need to be informed consumers. Provide them with the approved formulary, and when there is a revision made to the formulary, provide the revision. Provide them with a list of usual and customary charges, so they can understand what their responsibility is. Help them understand what the list of providers means to them, in terms of their choice of primary physicians, specialists, and institutions to which they can be referred for care. I am convinced that if you provide the consumer with that kind of information up front, that they will be good consumers and play by the rules that have been established by the managed care industry. But at this point they are being placed in the arenas of managed care without that information. They are getting caught up in an appeals and grievances system often because they never understood the rules to start with. The most important thing you could do is tell the HMO industry to provide this information to the consumers.

Study Group Member: This is an overwhelming task, but I am not sure that the sole responsibility falls to the HMO. There are employers, providers, and at some point, we the consumer have to assume some responsibility. I don't know how that will be formalized into a structure. We, as consumers, might be confused now, but we are not just victims. A question goes to the advocates; what are you doing to educate your patients about what they need to do to "navigate" through the HMO, and what sort of systematic surveys or other efforts are you involved in?

Patient #5: The Virginia Mental Health Consumers Association in conjunction with the Virginia Alliance for the Mentally Ill conducted a survey recently about HMOs. Someone at Harvard University studied managed care and found that access to information was lacking. Medicaid is doing a better job now at providing information. BMPA is planning to hold a town forum to help patients become better informed. We are only one small piece of the pie. There are many groups out there who are collecting information and conducting surveys, but it is not tied together in any systematic way. We hope that there will be some way to help patients, who, even with a book that tells them what they need to do, can't navigate the system. The Study Group has a chance to create a system to help patients, so they don't end up in the grievance process.

Department of Health #2: When patients are looking for help in a state agency, they often want help for their own specific problem. We can't look at the issue at that level, so what you (the advocates) are proposing is very valid.

The facilitator asked if there were any other advocates who would like to respond to the question of education.

VA Farm Bureau: Over the course of the past 23 years, we have seen an evolution in the health care industry. In the 1970's we were selling full-service coverage. Now we are beginning to see more concern about the costs, and HMO policies are the fastest growing block that we sell. The consumers are attracted to HMOs for a reason. I think that there is a lack of education in knowing the right person to contact. Subscribers can all tell me exactly how much they pay every month, but they can't tell me what product they have or the coverage they have. I am guilty of that myself. I have pushed the responsibility of knowing all the benefits that I have off on my employer. But these are real problems. We are looking for that easy solution, and I really don't think there is one. The consumer has to accept the responsibility, and I don't know how we can educate them. Fortunately, I don't hear the horror stories like we've heard here today.

Independent Appeals

AARP: We do not deal with individuals. Our programs are more general. We do have materials about managed care in general, consumer protection in managed care, and basically what a potential enrollee should look for. I would answer question #2, about whether enrollees are provided with enough information to understand the HMO system, that they clearly are not. Even in HB 2785 it says that HMO publications must provide information in clear English. That law goes into effect July 1, but are we not in effect saying that there does need to be a clearer understanding? Also, at the time an individual patient has a problem, is the HMO helping them, telling them how the process works? No, instead you have to go around the barn trying to find a way to access the process. Also, in the interest of fairness to everyone, there must be another step in the process, that is, an independent review with authority. Maybe the VDH can do it as part of another process. As long as they have the authority to follow up on the decision.

Study Group Member: I wanted to respond to AARP's suggestion for an external, independent appeals process. As I understand it, an independent review process would be something like arbitration where an independent person who isn't familiar with the case will be asked to decide the case based on the merits of the facts as presented. Maybe I have mis-represented it, but that is typically what I hear, when I hear about independent appeals. Is this really what patients and advocates want? I wonder whether an independent appeals process is really an appropriate fix. It strikes me that it is going to be pretty removed from the patient's situation. The decision will need to balance the disputing perspectives and cast a judgment, which will be final.

The facilitator asked the group to go around the room to give final comments and any responses to this characterization of an independent appeals process.

Closing Comments

Patient Advocate Foundation #1: California has just enacted, effective September 1997, legislation describing an independent appeals process. The appeals and grievances system had become very muddled as the HMOs tried to deal with the volume of concerns. The patient population felt there wasn't a fair appeals process, and by the same token, the HMOs felt they were also being victimized by the process. They've enacted legislation that describes very specifically the membership of the appeals panel. The California Department of Health has input into the members of the panel. There must be members of the provider community from the specific area of specialization in question. That legislation passed with no dissenting votes and with the full support of the HMOs. Anytime we can effect a reform that has the support of the managed care industry and the support of the patient population, perhaps we are beginning to get some answers. We can provide this to you, and it's on our website.

In terms of what we are doing to inform and educate, my experience is that we and other advocacy groups are trying to put information out there that will inform the consumer. I agree that we need to unite. I just returned from a meeting in Colorado of advocacy groups. We agreed to link our websites, so that readers can immediately access all the other information from all of the other consumer groups across the country. We've also published a book, *The Advantage Care Answer Guide*, which will be posted on our website as well. So we really are making an effort to educate and help consumers. We offer the opportunity for patients to interact with attorneys or with a case manager who practices case management with HMOs everyday to get

their questions answered by a human being, one-on-one.

Patient #1: How many around the table belong to an HMO? (most) So you know the types of problems that people have, and sometimes you voice them and sometimes you don't. As a consumer, I know that you officials don't hear 80% of the complaints. People don't know about the appeals process because 80% of the people out there aren't on the Internet and don't even own a computer. It's great for those who own a computer, but not for those who don't have one or aren't on the Internet. You are offering help to the smallest portion of the consumers.

The problem with HMOs is that they have built in deterrents to treatment. These deterrents are in the form of a co-payment or in the form of allowing a doctor to have 300 patients instead of 200 so you have a 3-hour wait in a doctors office and don't make an appointment. You stay home when you have the flu and take care of it. Your HMO makes money even if you don't go because you pay them every month. They say that you can have 20 visits for mental health, but you have to pay $25 a visit. What most people don't think about is that in a catastrophic situation, it's not just one person who needs help. My wife and I need help. That's $50 a month! I'm already bankrupt and in foreclosure on my house because of what's going on. I don't have $50 a month, so I'm not going to get treatment. It sucks!

Consolidated Coalition for Quality Health Care: This is an emotional issue and it demonstrates that all health care is personal, ultimately. However, the other side of the story is that managed care, if done right, can accelerate the quality of the healing process. This can be accomplished through building an integrated patient-centered, consumer-centered, delivery system that is accountable for improving the health care status of enrollees. That is a wonderful and possible vision. Today and everyday, we are hearing that the industry is not living up to that vision. They're in a better position to live up to it than the fee-for-service delivery system was. In that system, you have physicians in isolation with no accountability and no peer review. I have seen rural doctors who were loved by their patients but practicing 1950's medicine. We need to recognize, and I think consumers do recognize, that managed care is here to stay. The challenge is how to make it work for consumers. With that as our goal, integrated, consumer-centered, accountable delivery systems need to be put into place to give consumers the confidence that managed care is reaching that vision. This is not simply developing an elaborate financing scheme to give incentives to providers to provide less care to consumers. We are hearing that often firms take financial risk, pass it on to consumers, and then walk away from building an integrated delivery system.

What do we need?

Licensing standards: I would urge the study group to look at the licensing standards for HMOs in Virginia to make sure that they each meet the challenge of having the best practice standards in place, that they meet the minimum standards we should set for any HMO. This relates to a comprehensive provider network, prudent lay person emergency service, internal grievance appeals, and the other basics that we should expect from every HMO.

Consumer information: Consumers need to have information as enrollees. They need to understand the appeals and grievance mechanism, their benefits, utilization management, and how they get to see a specialist. They also need information to help them choose an HMO, such as information about quality performance on a comparative basis. Many consumers don't even have a choice of a health care plan. Their employer picks the plan for them. One of the things the state could think about is how to expand consumer choice. If you

had choice, and people were picking not on the basis of the lowest premium cost but on who is achieving the best results for patients, we could provide some competition in the market place based on quality not cost. Often employers do go with the lowest cost, no offense meant to the employers sitting around the table.

Comprehensive population-based monitoring system: This should focus on the primary issue concerning HMOs, namely access to care. We have data and technology now that would allow the state to routinely monitor the utilization rates of plans to make sure that people are getting appropriate referrals to specialists, that hospitalization rates are what they should be, etc. This can build a system in which we can be sure that quality of care is there and that we are improving quality of care.

External appeals system: I would endorse an independent appeals process. I think Dr. Daniels was describing the Administrative Law Process, which is the ultimate appeal to the state. There could be an intermediary external appeal, like we have in the Medicare program, which is a smart group of independent practitioners who independently investigate the case and render a professional, medical opinion on it. That process can be expedited and quick, but the basic principle is that it is independent of the plaintiff. If the reconsideration process is within the plan, then the plan is judge and jury.

Knowledge of appeals system at the time of denial of care: When an individual is denied services or services are reduced or terminated, they need written notice that there has been denial of a service, and at that moment, they need to be informed of what the appeals process is. That is when they need the information to act on. You forget it when you are enrolling, but you need it then. I think that this is a very exciting journey. Our job here is not to come and criticize managed care. Managed care can be an exciting advance for patient health care. Good managed care plans do exist, but we've got to figure out a way to make sure that all plans are being held to appropriate standards.

AARP: The previous comments sum up everything that I was going to say, but I want to follow up on the computers. Most of the people who are going to be at the critical point of needing help with the appeals process are likely to be frail, elderly, indigent, or poor. They don't have computers, so don't forget the written word as a way of educating and informing consumers.

Department of Health Professions #2: I feel good that I have heard all of the problems that I came with mentioned during this meeting. As a complaint analyst with the DHP, I hear all kinds of complaints. One of the things that we have to do is help people sort out who the complaint is really about. That is not always easy. If the patient has a complaint about the quality of care received from their provider, how much of this complaint can be attributed to the HMO? One more thing is that recently we have seen more complaints from providers who are concerned about the quality of the utilization reviewers. These complaints are becoming rather vehement. We also get the impression that consumers believe that HMOs are somehow endorsing the providers on their listing. Consumers are expecting an on-going screening and evaluation of providers.

Medical Society of Virginia: Those consumers who have some knowledge and can push seem to get results. Unfortunately, the vast majority of consumers are not able to do that, and that majority is going to increase. Especially now that the Medicare population is being moved into HMOs, advocacy will be very important for these individuals, who frequently have difficulty getting through any kind of system. I don't know how we can make it any easier.

VA Power: The issues raised here are coming from a lot of different sources and are very dynamic. It is very important to try to look at this in a systematic and logical way. The individual cases are very important, but also, the group should try to get at the heart of other issues that are very prevalent. These issues should be

prioritized so that the group can deal with them effectively within the time and resource constraints. It is difficult to unravel so many issues at once. I would also like to add that employers are concerned about quality. We look at networks and the credentials of providers.

VA Farm Bureau: We need to educate consumers about the difference between HMOs. We, as employers, have that responsibility. There are a lot of good service vehicles out there, and the Bureau does a good job at monitoring problems. I don't think there are any quick solutions to this issue, and I don't envy your job.

VA Health Quality Center #2: An independent, third-party complaint process is anything but a cold, heartless process. People call us because they have tried to work it out with the HMO but they can't get through to the insurance companies or don't get a response. They also call because it's toll-free. People are very angry when they call our organization, and we get very familiar with the people and their problems. There are significant benefits to the process. Also, we have been talking about a chicken/ egg situation. Is it better to improve the system so that we don't have the problems and complaints, or improve the system to deal with the complaints? In the same argument, we can either prevent crime and prevent problems from happening, or we can pay the price by building more jails. We need to prevent the complaints from surfacing at all.

Patient #5: I have concerns about people saying that the responsibility lies with the patients. I know a Medical Director who didn't know what to do. We need to help everyone become partners in health care through patient education AND provider education. I hope the Study Group does not put any more money into grievance procedures but focuses on avoiding grievances down the road. They need to put money and ideas into bringing people together so that we can become partners in health care, and so that people can be educated and work better together.

Benova: We function as an enrollment broker for Medicaid. We try to both enroll and educate. Medicaid is changing, and people are just receiving letters saying that they have to enroll in an HMO or one will be chosen for them with no explanation. People call up saying that they just want to be on "normal Medicaid." We need to educate people about the process and focus on the preventative. We need to help the consumer know that the doctor can refer them to a specialist and all of the other things that we have been talking about during this meeting.

VA Health Quality Center #1: I would like to make a plea for simplicity. The system is complicated and fragmented, we don't need to add more complications. The argument for an independent review is very appealing. Often patients are concerned that they will not receive good care because they have complained. Also, through an independent and centralized system, the state could track trends and look at patterns of problems. The review system could also be expanded to be responsible for tracking, monitoring, and for developing mechanisms for improvement.

VA Department of Personnel and Training: One of the most compelling issues that we deal with that often does not reach the appeals level, is the help that people need when they are transitioning from one level of care to another, such as a transition to home care. We need better definitions of what is allowable. People go home not knowing how they are going to care for themselves. This type of thing must come from the providers. Providers call us about these problems because right now, the appeals must be filed by physicians. More obvious problems usually get solved. It is the more subtle problems that are not so easily solved.

Rash & Associates: One of the most important issues is communication. The biggest problem is not understanding the rules. Employers and purchase consultants must communicate those rules to the

consumers. One practical solution is inviting spouses to the informational meetings. At the risk of sounding sexist, often the health of a family is overseen by the wife, who rarely gets to hear an explanation of the plan. This type of communication does not require regulation so much as it requires common sense.

People want choice. Employers should offer both HMO and point of service plans, so the employee can choose the most appropriate plan.

In the referral process, the "gate keeper" should be skipped. Patients should be able to see specialists, as they need them. There are good plans, and hopefully, the mediocre plans will fall by the wayside as the health care evolution continues.

Often there is a disconnect from the providers. I have seen an underlying resentment towards HMOs, and that is surfacing in the form of "disinformation" from providers to patients. They make the HMO look like the bad guy. The patient is squeezed in the middle, and they get nervous. To create a partnership in health care, the communication must start with the providers. Patients expect providers to take care of all of the paperwork and expect everything to be done for them, but they must be made to realize that they too have a responsibility and be helped to understand what that responsibility is.

One more very important suggestion deals with the denial of claims. The consumer must know immediately that the claim has been denied, not two weeks later. People get frustrated when they have to wait to hear that they have been denied a form of health care that they felt they needed.

Dr. David Buchsbaum, Medical Director for Aetna US Health Care Virginia: During this discussion I have been thinking about our own policies and procedures for dealing with managed care. I am gratified to know that this conversation is going on. No more than 20 years ago, health care was a private affair between a doctor and a patient behind closed doors. Now we are making physicians accountable to the citizens of the Commonwealth. Our company is devoting an enormous amount of time to quality and enforcing accreditation rules. I think we are evolving, and we do listen. This is a dynamic process, so consumers, providers, HMOs, and the state are coming together to move forward through the process together.

Patient Advocate Foundation #2: We have heard some frightening stories about barriers to care and restrictions. I want to look at the broader picture of potential solutions to these barriers and restrictions. We could get out our band-aids, we could get out bigger regulatory sticks, but these would be short-term solutions. We need to seriously consider the structure of the system, particularly minimum expectations. We also need to help employers know what kinds of information they need to provide and help consumers know how to use the system. The system has to be improved overall. There should be recommendations about a new, overall structure for the system.

Dr. Daniels concluded the Roundtable, thanking the participants for their time and contributions.

A summary of the Roundtable session will be posted in June at the website address: http://www.vdh.state.va.us.

The following letters were received from interested parties and are included as part of the summary of the Focused Roundtable for Consumers:

PATIENT ADVOCATE FOUNDATION
A National Network for Healthcare Reform
739 Thimble Shoals Boulevard, Suite 704
Newport News, VA 23606
Tel: 757-873-6668; Fax: 757-873-8999; E-Mail: ndepaf@pinn.net

May 22, 1997

RE: Meeting with HB2785 Study Group

TO: Committee Members

FROM: Nancy Davenport-Ennis
Founding Executive Director

Thank you for your investment of time, energy and expertise in examining issues relative to ERISA plans in which the employer pays health care claims directly, although an insurer or HMO may be retained to administer the plan and disburse the claims payments.

Our experience reflects the following as factual:

1. Capitol Care of Northern Virginia makes arbitrary and capricious reviews of cases that involve both quality of care issues and access issues. Two patients who have been represented by our attorneys have had Capitol Care cut off all coverage for their medical services while they were hospitalized with medical emergencies. One patient, a thirty-five year old male, was forced by Capitol Care to be moved from one treatment facility to a distant facility. The treating physician warned Capitol Care that this move could be fatal to the patient. The Capitol Care representative insisted upon the relocation of this patient. The patient died upon arrival at the distant location.

2. G.W. Health Plan of Washington, DC does not approve primary care given referrals to specialized care routinely and the result is loss of life. If a referral is approved, which is seldom, the patient is directed to carve-out specialists which historically mean geographical relocation. Experience reflects that a high percentage of those referred to distant locations do not accept due to increased hardship on their family financially and personally. Further, this company routinely denies care until the patient's condition reaches a stage that does not allow for them to be treated.

3. Cigna Healthcare of Virginia manages the ERISA program for the hourly workers at Newport News Shipbuilding. See the attached BROWN case for an example for which therapy is being denied to a newborn girl who suffered oxygen deprivation during birth based on TRIGON's interpretation that

they do not cover developmental therapy: they only cover rehabilitative. They have determined that this child's therapy is developmental. In the 1997 General Assembly, House Bill No. 2716 has been passed into law requiring insurers to provide coverage for "early intervention services including medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age appropriately within his environment, and shall include services which enhance functional ability without effecting a cure." This legislation goes on to state "there shall be no denial of coverage due to the existence of a pre-existing condition." With this law in place, we made an appeal to the employer to review this case with the HMO managing their ERISA plan. No revision in coverage has been made for this child.

4. Prudential Health Care Plan of the Mid-Atlantic has also been cited as refusing coverage for Autologous Peripheral Stem Cell Transplant on the grounds of "medically necessary." Plan language states "care is considered medically necessary when it is accepted by the health care profession as appropriate and effective . . . and it is not experimental and investigational." Certainly legislative bodies in ten states would refute this language, including Virginia, as would the federal government 1994 OPM mandate covering federal employees.

5. TRIGON Blue Cross Blue Shield denies Autologous bone marrow transplantation for Waldenstrom's Macroglobulinemic citing it is not covered in the patient's benefit program. Our experience reflects that the ERISA plan relies upon the direction of its management entity for references of what coverage benefits to include in their employees plan language.

6. TRIGON Blue Cross Blue Shield denies ABMT for ovarian cancer stage III for 35 year old patient due to "service is not included in plan benefit." The employer and plan manager determines what is in the plan benefit.

As long as ERISA plans are exempt from the laws of both states and the federal government that define coverage criteria and expectations for consumer protection and minimum standards required to offer benefits that reflect integrity and continuity, citizens will continue to experience rationed healthcare, redirection to distant service providers, random, capricious and arbitrary coverage decisions and continued denials based on conflicting policy language. The primary example of conflict of interest is policy language that states "medically necessary" services will be covered only later to be excluded in specific exclusion language defined by the plan.

Reform of ERISA requirements is required to define integrity in self-funded plan management.

PERMA TREAT
PEST AND TERMITE CONTROL

22 May 1997

Ms. Alison Croke
Department of Health
Fax: 804-371-0116

Dear Ms. Croke:

I regret that I will be unable to attend the focus group session tomorrow to discuss H.2785.

I am the owner of PermaTreat Pest Control, serving fourteen counties in the Northern Virginia area, with sixty employees. In 1987, PermaTreat was names Virginia's Small Business of the Year by the U.S. Small Business Administration.

I am vice-chairman of the board for MediCorp Health System and past chairman of the board for Mary Washington Hospital. I feel that I have a well-rounded view of health insurance issues from three directions . . . the employer, the provider, and as an employee, since I and my family are members of an HMO. I provide health insurance to my employees and their families, and I have the following observations to make:

- Competition in the insurer/provider field has been intense and, overall, has worked very well to help reduce insurance costs to employers. At one time, I was considering dropping group insurance for employees because the cost was becoming astronomical. Blue Cross/Blue Shield hit me with a 43% rate increase in one year. Competition has brought the rates back in line and our increases seem to be confined to single digits, which is bearable.

- Government should stay out of health care as much as possible at this point and let the market adjust itself. Most of the problems involving insurance will probably solve themselves over a period of time.

- Almost all plans offer the choice between the HMO approach and the traditional point-of-service plan. If my employees are unhappy with the panel of providers presented by our HMO, then they can opt to take the point-of-service plan and see any doctor they wish. This approach costs a few dollars more - $5 or $10 per month more.

- Providers dislike HMOs for obvious reasons. Some employees may complain because they cannot see the doctors they want under their HMO plan, but they certainly don't complain about the savings in premiums.

I firmly believe that, over a period of time, we will all get used to the system and we will all save money.

Personally, I am extremely pleased that I am able to continue to provide health benefits to my employees without having to pass on a larger and larger portion of the premium.

Thank you for the opportunity to express my points of view.

Sincerely,

PERMATREAT, INC.

Joe R. Wilson
President

APPENDIX L

EXPERIENCES IN OTHER STATES

APPENDIX L: SELECTED STATES WITH AN OMBUDSMAN OR EXTERNAL CONSUMER APPEALS PROCESS

House Bill 2785 directs the State Health Commissioner to examine whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans, and if so, whether the Department of Health or another entity should administer the process. The method for examining this question consisted of interviews with selected states which had an ombudsman or a consumer appeals process external to HMO internal complaint systems. The interviews were conducted during the months of March (subject to legislative changes) and August 1997.

Currently, all states require HMOs to have a grievance procedure in place. More than 30 detail specific procedures for the complaint system. The Center for Health Care Rights reports that 22 states explicitly provide HMO enrollees the right to take their grievances to the state, with seven of those requiring that the enrollee must first exhaust the HMO internal appeals process (Dallek, 1995). It should be noted that, while the right to complain may appear in state code, the degree to which states exercise their authority is unknown at this time. For example, California recently strengthened its procedures for the monitoring of enrollee grievances, and began to publicize a toll-free hotline, after receiving bad press from several highly publicized cases with adverse outcomes. Currently, no states provide adjudicative authority for enrollee/HMO disputes. New York limits binding arbitration by managed care plans with their enrollees. Alabama requires significantly detailed grievance procedures for HMOs operating in the state (Families USA, 1996). Mississippi recently enacted legislation providing the health department with authority for quality of care oversight, but regulations have not yet been developed (NASHP, 1996). Other states, such as South Carolina and Tennessee, have not yet implemented these special protections. Some states have begun to examine the feasibility of implementing these special consumer protections. The experiences of some of these states are detailed below.

California

A pilot ombudsman program serving all managed care consumers in the Sacramento area will be financed by three private health foundations, the Henry J. Kaiser Family Foundation, Sierra Health Foundation and California Wellness Foundation, and administered by the Center for Health Care Rights (CHCR). Funding for this 4-year project is $4 million, with an initial 2-year award of $1.6 million. The program will address managed care questions and handle specific complaints with plans, and is scheduled to begin in March 1997 (JCHC, 1996)

Colorado

This state recently enacted a new insurance regulation involving consumer appeals of claim denials. The new rule applies to all health plans that employ utilization review in their claim determinations. Health plans affected by the rule are required to 1) develop written standards for making UR decisions and communicating decisions to covered persons and their providers, 2) make the UR decision within two days of receipt of all information relevant to the decision, 3) notify the insured and provider by telephone of adverse decision within one day, 4) notify the provider by telephone within one day of decision after an admission, 5) make determinations on retrospective review within 30 days, and notify provider and insured of adverse decision within 5 days, 6) provide in writing the reason for an adverse determination and instructions for appeal, and 7) reconsider adverse determinations within one day of request. Appeals are to be considered by a peer of the treating provider. A covered person may request a second level grievance review of a still unresolved grievance, for which the carrier must appoint a grievance review panel. The rule also addresses expedited appeals.

Connecticut

In this state, PA 97-99 generated from House Bill 6883 allows an enrollee or his provider acting for him, once he has exhausted all internal appeals procedures of a managed care organization (MCO) or Utilization Review (UR) Company, to appeal to the Health Commissioner. The Health Commissioner contracts with an independent source which is either an independent UR Company, a Peer Review Organization (PRO), or nationally recognized health experts or institutions. In the state of Connecticut, the decision by the external review agent is binding.

According to the Senior Attorney of the Office of Legislative Research, the evidence of a need for an external review was mainly anecdotal. There was a basic skepticism that HMOs were not objective in their decisions, and there was a general belief that consumers weren't aware of the grievance procedures. (This belief was not concluded from a consumer survey). The state did conduct a survey of HMOs' clinical procedures and from this survey realized that the state of Connecticut had an overabundance of drive-thru deliveries and 24 hour mastectomies. It was this type of evidence that they used to determine a need for an external appeals process.

Florida

Since 1985, Florida has administered a Statewide Provider and Subscriber Assistance Program (SPSAP), which hears enrollee grievances against HMOs that have not been resolved to the enrollee's satisfaction (Agency for Health Care Administration, 1996). Responsibility for hearing provider grievances, such as those involving quality or continuity of care, was added in 1993. Enrollees who have exhausted the managed care entity's internal appeal process must be told by their plans that they may make a written appeal to the Agency for Health Care Administration, which reviews the case to determine if it will be selected for hearing by a six-member panel, composed of representatives from the Agency and the Department. The panel hears the case and makes a recommendation to the Agency or Department, depending on which has regulatory authority for the case. The Agency or Department issues a final determination, which, although not binding on the plan, may lead to imposition of fines if the plan does not comply. The program also reviews quarterly unresolved grievance reports submitted by managed care entities. Initially, responsibility for the program fell to the Department, but was transferred to the Agency in 1993. The volume of cases rose from 26 in 1991, to 140 in 1995. Day to day operations of the program are handled by two FTEs housed in the Agency. The panel members serve as needed, and the requirements of the panel are included in their job descriptions.

The Agency also operates an HMO hotline, which receives approximately 2,000 calls per month. In addition, a Volunteer Statewide Managed Care Ombudsman Committee within the Agency for Health Care Administration is currently being developed, and will serve in a consumer education, protection and advocacy role. Legislation is only now being explored, so the functions of the ombudsman and a determination of staffing and funding requirements are not yet available. Indications are that the ombudsman will assist consumers who have not yet exhausted the internal appeals process, and will provide a link between the hotline and the SPSAP (Personal communication, 1996).

Maryland

Since 1986, a Health Education and Advocacy Unit has operated within the Office of the Attorney General. Two FTEs plus a trained volunteer staff (retired health care and insurance professionals, student interns from medical and law schools) mediate consumer complaints and educate consumers. The annual volume of 4,000-6,000 calls on their toll-free hotline results in approximately 1,000 complaints, involving Medicare, Medicaid, indemnity-insurance, managed care plans and third party administrators. The unit initially received only billing questions, but in recent years has received a growing number of complaints regarding medical necessity and quality of care. While the unit does not directly handle complaints against physicians and health professionals regarding quality of care or diagnostic accuracy, they will accept such complaints and forward them to appropriate regulatory boards for review. The unit also has the regulatory authority to monitor the progress of complaints referred to

regulatory boards or the Insurance Commissioner (Maryland Consumer Courier, 1990). As part of the AG's Consumer Protection Division, the unit has regulatory authority over violations of consumer protection laws, but has no adjudicatory authority. The unit will take calls from providers, but only on behalf of patients. Complaints are tracked by industry and type of complaint. Approximately, 80-90% are resolved in 4-6 months. The success rate is 75-85%, and is based on the consumer's initial request. The annual budget of approximately $100,000 is funded through the Office of the Attorney General (Personal communication, 1996).

New Jersey

Chapter 26 of the New Jersey Administrative Code outlines that state's external review process. Any HMO member, and any provider acting on behalf of an HMO member with the member's consent, who is dissatisfied with the results of an HMO's internal appeal process, has the right to pursue his or her appeal to an Independent Utilization Review Organization (IURO). An appeal to the IURO must be made within 30 business days of receiving a final Stage 2 decision from the HMO. An IURO designated by the New Jersey Department of Health and Senior Services will determine whether the member was deprived of a medically necessary covered service, as a result of the HMO's utilization management determination. The Department will assign appeal requests to an approved IURO. The IURO has 30 business days to complete the preliminary and full review of the appeal. If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend in writing to the member and/or provider, the HMO and the Department, the appropriate covered health services the member should receive. The HMO then decides whether it will accept and implement or reject the recommendation offered by the IURO.

According to the Chief of the Office of Managed Care in the New Jersey Department of Health, this legislation came about as a reaction to a general perception that HMOs were inappropriately denying care to certain groups of enrollees. He added that there was confirmation of this from many interest groups, especially the New Jersey Medical Society and the hospital industry. Some data on HMO denial was brought to their office's attention. The Chief stressed his opinion that the decision to establish external review was not an arbitrary reaction but rather a response to the perceived ineffectiveness of the HMOs' internal review processes.

Rhode Island

According to the Rhode Island Administrative Code, in cases where the second level of appeal to reverse an adverse determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective appeal agency, selected by the Director of the Department of Health. The external appeal review and decision is based on the medical necessity for the care, treatment, or service, and the appropriateness of service delivery for

which authorization has been denied. The decision of the external appeal agency is binding on the health plan; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to a judicial review in a court of law.

External Review of Appeals legislation has been in existence in Rhode Island for 3 years; it was the first of such legislation in the country. As explained by the Managed Care Officer for the Rhode Island Department of Health, it was originally proposed by a legislator who had a son who committed suicide because he was denied care by his HMO. This legislator pushed the proposal through the General Assembly, convincing the state government of the need for this legislation because of the existence of a trend for HMOs to deny care. When contemplating the passage of the bill, the General Assembly heard supporting testimony from consumers and the mental health community.

Medicaid Managed Care Ombudsman Programs

The Center for Health Care Rights was to publish a report in December 1996 summarizing the experience of 14 Medicaid managed care ombudsman programs (Center for Health Care Rights, 1996). It is not yet available, but will contain information on issues that may be considered in developing an ombudsman program, as well as data on the experiences of 14 Medicaid managed care ombudsman programs throughout the country. Not included in the report is Maryland, which is scheduled to begin a Medicaid managed care ombudsman program in March 1997. Virginia's Department of Medical Assistance Services (DMAS) does not operate an ombudsman program for Medicaid managed care enrollees (although it operates a recipient assistance line), but instead operates a formal appeals process.

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State Comparisons of Independent External Appeals Process

Methodological note: Information in this analysis is based on a review of current law and/or regulation. Most are recent (RI's law has existed for three years; CT's law is in the rule-making process; VA passed its law in 1995). Phone interviews with selected states were conducted to verify interpretations. The UR processes reviewed involve the standard process, not expedited review.)

Characteristics	VA	NJ	CT	RI
Type of decision being appealed	UR adverse decision	UR adverse decision	UR adverse decision	UR adverse decision
External				
When does an appeal become external?	*(As part of but not after the appeal of the reconsideration of adverse decision -- 2nd level)*	*After* the final stage 2 decision	*After* exhausting all internal appeal procedures	*After* the 2nd level of appeal (final level)
Relation of the reviewer to the plan		Independent UR organizations	"independent & impartial"	"unrelated objective agency"
Independent				
Qualifications of the reviewer	Peer of the treating health care provider specialized in a discipline pertinent to the issue under review	Qualifications not stated; but Health Commissioner may establish qualifications	Nationally recognized health experts	Licensure the same as the ordering practitioner or a licensed physician or dentist as appropriate
Relation of the reviewer to the plan	Not be employed by or a director of the utilization review entity	Independent UR organizations	"independent & impartial"	"unrelated objective agency"
Reimbursement arrangement	Plan pays the reviewer directly	Health Commissioner establishes fees for external review; plan pays the Health Department	Enrollee pays a $25 fee process claim (*In CT, the Insurance Department is funded through fees from the insurance companies; presumably insurers cover the balance)*	50% paid by patient or provider of record & 50% paid by organization that denied coverage
Selection of the reviewer (individual or organization)	Plan appears to designate the individual to review. BOI/ Commissioner of Insurance has no role; Department of Health/ Health Commissioner has no role	Department of Health & Senior Services/ Director designates the reviewing entity	Insurance Commissioner, after consultation with the Public Health Commissioner designates the reviewing entity	Department of Health/Director designates the reviewing entity
Reviewer's involvement in previous decisions or reconsideration by the plan	No previous involvement	No previous involvement	Presumably no previous involvement	No previous involvement

Authority of the reviewer	Uncertain (no explicit statement in Code) as to whether the decision made by the reviewer is binding on the plan	Recommends to the HMO for its consideration appropriate treatment	Binding on the HMO law does not address whether the dissatisfied party has recourse through the courts.	Binding on the HMO: unsatisfied enrollee has recourse through the courts

Outline of the process in Virginia as defined at section 38.2-5406ff
(Standard process not expedited)

- Request for treatment
- Adverse decision
- Reconsideration of adverse decision (first level)
- Final adverse defemination
- ***Appeal of final adverse determination (2nd level)***

APPENDIX L: A SURVEY OF VARIOUS STATES' REGULATION OF MANAGED CARE ORGANIZATIONS' QUALITY ASSURANCE

Introduction

The states chosen for this survey were selected based upon a recommendation made by staff of the National Committee for Quality Assurance (NCQA). The majority of the states in the survey regulate quality assurance functions of managed care organizations (MCO) through their states' health departments as part of a bifurcated regulatory system that also includes the states' departments of insurance.

State managed care regulatory administrators in the following states were interviewed: Florida, Nevada, Oklahoma, Pennsylvania, Rhode Island, SouthCarolina, Vermont and Minnesota. In addition, contact was also made with the chairperson of the National Association of Managed Care Regulators' committee studying the feasibility of national model managed care regulations and personnel from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCAHO has recently adopted quality assurance standards for accrediting managed care organizations and is attempting to qualify as an MCO external quality assurance review organization in those states that require managed care organizations to undergo external reviews.

Among the states that were surveyed, the primary difference between the states' regulation of MCOs' quality assurance is in regard to the extent that a state itself takes an active role in the evaluation of managed care organizations' quality assurance programs as compared to relying primarily on the findings of an independent external review organization.

States' expectations for MCOs' quality assurance programs are basically the same among the surveyed states as evidenced by the states' requirements for:

Data collection and analysis of access, accessibility, continuity and coordination of health care services.

Defined service areas

Monitoring of health care outcomes

Processes for:

Internal quality improvement assessment
Peer review
Complaint resolution
Appeals
Medical audits
Remedial action to correct identified deficiencies

Procedures for:

Corporate accountability
Reporting of quality assurance activities to state public health personnel

PENNSYLVANIA

PLAN REVIEW

Prior to the time that the Pennsylvania Department of Insurance initially issues a Certificate of Authority to a MCO, the Department of Health's Bureau of Quality Assurance has reviewed the MCO's quality assurance procedures that are part of the organization's application for a Certificate. The organization's quality assurance procedures are reviewed for compliance with the Department of Health's statutory and regulatory quality assurance standards for managed care organizations, which Pennsylvania Health Department personnel attest go beyond NCQA's standards.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Pennsylvania's Health Maintenance Organization (HMO) regulations require that, within one year of the receipt of a Certificate of Authority, and every three years thereafter, or when the Department of Health shall direct for cause, each HMO shall have an external quality assurance assessment performed. The Department of Health also conducts a state onsite quality assurance review, sometimes in coordination with the external review organization. The Department then gathers all of the quality assurance assessment information and issues a report to the MCO and to the Department of Insurance as to whether or not the Commonwealth's standards for MCO quality assurance have been met by the organization.

External quality assurance reviews may only be performed by organizations that are approved by the Department of Health, based upon the organization's recognized experience in the appraisal of medical practice and quality assurance in a MCO setting.

Pennsylvania sends out an **Invitation to Qualify as a Quality Review Organization (QRO)** to interested applicants. The Commonwealth has approved three external QROs with approval of a fourth organization pending. The three that have been approved are the Accreditation Association for Ambulatory Health Care, Inc., the National Committee on Quality Assurance (NCQA) and Health Pro, Inc. of Massachusetts. The approval of the Joint Commission on the Accreditation of Health Care Organizations is pending.

Before the Department approves a QRO, the organization must perform one free demonstration external assessment of a MCO designated by the Department. Organizations whose performance is unsatisfactory during the demonstration assessment are not granted approval. The Department also requires that the QRO include a list of terms and conditions placed upon the review organizations by the Department in their contracts with the MCO, including the Department's right to participate in each external review. Approval status of a QRO can be removed at any time if an organization fails to meet the Department of Health's standards. On an annual basis, representatives from each approved QRO must travel to the Pennsylvania Department of Health for a meeting to evaluate the effectiveness of the external quality review approach.

Pennsylvania MCOs are responsible for selecting from among the state-approved QROs one to review their organization and are responsible for paying for and scheduling the reviews. The Department is not a party to the contracts between the MCO and the QRO and it assumes no financial responsibility for any aspect of the review. Neither does the Department guarantee the performance of any of the approved Quality Review Organizations. The QRO reports are submitted to both the MCO and to the Health Department and are not public documents. They are used only by the Department for evaluating the MCO's quality assurance program.

STATE ONSITE REVIEWS

Department of Health, Bureau of Quality Assurance personnel (approximately thirteen staff members), conduct the administrative desk review of the MCOs' quality assurance programs as well as conduct onsite quality assurance reviews. In some instances, the Commonwealth's surveyors accompany the QRO surveyors. The Bureau issues a report that is combined with the external review organization's findings. It also conducts complaint investigations. According to Pennsylvania state authorities who work with MCOs, most MCOs work fairly cooperatively with the Commonwealth to correct quality assurance problems in the interest of avoiding negative publicity. Funds to support the Commonwealth's Department of Health MCO quality assurance oversight come primarily out of the fees assessed by the Commonwealth for initial Certificates of Authority and renewal certificates. Currently, Pennsylvania has 25 certified HMOs with three million people enrolled in the HMOs.

VERMONT

In Vermont, the regulation of managed care organizations originated in the Department of Banking and Insurance. The Vermont legislature later determined that this department was not the appropriate agency to deal with health care quality assurance issues and created the Vermont Health Care Authority (VHCA). An executive branch agency, VHCA, is responsible for strategic planning for health care reform and health care issues, as well as all health care policies and regulations.

PLAN REVIEW

The Vermont Health Care Authority is responsible for reviewing the quality assurance procedures of each applicant MCO and existing MCOs. MCOs that apply for a Certificate of Authority must first have the approval of the VHCA that their quality assurance procedures agree with Vermont's MCO quality assurance regulations and statutes before they are issued a Certificate of Authority. Vermont's statutes and regulations governing quality assurance are less comprehensive than Pennsylvania's and, according to VHCA personnel, are subject soon to revision.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Vermont's process for approving external MCO quality assurance review organizations mirrors that of Pennsylvania's through the solicitation of bids from accreditation agencies such as NCQA. Vermont law requires a MCO to be subject to a quality assurance evaluation every three years or more often if necessary. VHCA has the authority to designate who may conduct the quality assurance review, and as of now, has only allowed approved MCO accreditation agencies to conduct the reviews. The approved accreditation agencies for Pennsylvania have also been approved by Vermont. Cost is a factor in regard to what accreditation organization a MCO might choose, with the larger MCOs opting for NCQA while the smaller organizations tending to choose"Triple A", i.e., the Accreditation Association for Ambulatory Health Care, Inc.

STATE ON-SITE REVIEWS

A state onsite review of quality assurance is required by Vermont law, however, the Vermont Health Care Authority does not conduct the state's review but contracts with a New York-based audit group, "Island Pro." Island Pro conducts reviews in New York for the Medicaid program, and according to VHCA personnel, has the needed expertise to conduct the external reviews of MCOs' quality assurance programs in a way that is more cost effective for Vermont. VHCA's personnel review the external and state quality assurance reports and make a recommendation to the Department of Banking and Insurance regarding the MCO's compliance with state law governing MCO quality assurance prior to the time a Certificate of

Authority is issued. VHCA has four staff personnel dedicated to quality assurance compliance. There are six certified HMOs in Vermont. Subscriber complaint review is conducted by VHCA and, according to VHCA personnel, the HMOs in Vermont have been willing to correct their quality assurance problems when identified by the VHCA. Funding for the quality assurance functions of VHCA comes primarily from MCO applications and certificate fees.

FLORIDA

PLAN REVIEW

Managed care organization regulation in Florida is shared between the Florida Department of Health Care Administration and the Florida Department of Insurance. The Department of Health Care Administration administers the MCO quality assurance reviews by dividing the reviews into two administrative sections: Medicaid contractual plans and commercial HMO plans. Florida's quality assurance regulation for MCOs is unique among most of the states surveyed in that, within a two year time frame after initially receiving a Certificate of Operation from the Department of Insurance, a MCO must actually receive accreditation by an external review organization or risk loosing its Certificate. This differs from most of the other states surveyed that incorporate an external review organization assessment in that the other states limit their regulations to requiring that the MCO undergo a review by an external review organization but they do not require actual accreditation by the review organization.

COMMERCIAL PLANS

The commercial plans are also required to be preapproved by the Department for compliance with Florida's statutes and regulations governing managed care quality assurance and must pass an initial survey conducted by the Department personnel before they are issued a Health Care Provider Certificate. A copy of the Certificate is sent to the Department of Insurance that issues the Certificate of Operation. Florida's commercial MCOs must be accredited by an external accreditation organization within two years of being issued a Certificate of Operation. If a MCO fails to be accredited within the given time frame, the state conducts a compliance survey that is similar to the initial state survey to review areas requiring quality improvement. A survey is also conducted by the state when a MCO wants to expand its service area.

Department field staff who are nurse consultants also conduct complaint investigations in regard to quality of care issues. Non-compliant MCOs are sent a statement of deficiencies and must file a plan of correction within ten days of receipt of the deficiency statement. Sanctions for the revocation of the Health Care Provider Certificate are provided for in Florida law. The fees a MCO files with its initial application for certification ($1,000) and the renewal fees ($1,000) go towards supporting the Department of Health's quality assurance compliance activities, as well as a yearly assessment that a MCO must pay to a state trust fund. The MCOs

are responsible for all costs associated with accreditation.

MINNESOTA

PLAN REVIEW

Minnesota regulates managed care organizations entirely through the Minnesota Department of Public Health. The license to operate a MCO is issued through the Department of Public Health.
Minnesota's statutes and regulations that govern MCO quality assurance emphasize the importance of MCOs having their own system of quality assurance evaluation with the state's role identified as assuring that the systems are effective through periodic examinations of the systems. The entire MCO application review is conducted by the Department of Public Health, rather than the Department conducting only the quality review aspect of the application as is done in most of the states surveyed. Audit staff conducts the review of the financial portions of the applicant's plan which is combined with staff review by health facility personnel of each plan's quality assurance process. Minnesota has approval for 21 full time employees to conduct MCO desk and onsite reviews.

ONSITE QUALITY ASSURANCE REVIEWS

STATE ONSITE REVIEWS

While Minnesota requires that each MCO's quality assurance process be examined no less than every three years, these periodic examinations are conducted only by Minnesota Department of Health staff. Minnesota does not require an external quality review process by state-approved review organizations such as NCQA.

Minnesota's Department of Public Health has the authority to apply sanctions for the failure of MCOs to comply with MCO quality assurance statutes and regulations. The most serious sanction allowed is the revocation of the MCO's license. Although not a common occurrence, Minnesota has required some HMOS in the state to pay sizable penalties for noncompliance with state quality assurance laws. The financing of Minnesota's regulatory MCO program comes primarily from licensure application fees ($16,000 base and $.46 per member) with separate fees ranging from $2,000-$3,000 for the periodic examinations. Minnesota currently licenses 16 managed care organizations.

OKLAHOMA

PLAN REVIEW

The Oklahoma Department of Health issues the license to operate a MCO with the Department

of Insurance having review and comment authority. Oklahoma reviews MCO plans to assure that the quality assurance plans and utilization programs meet state statutes and regulations. Oklahoma's quality assurance standards are similar to federal HMO qualification rules under 42 CFR, Part 400429, Section 417. 106.

The Oklahoma Department of Health MCO section has a Licensure and Quality Assurance unit with four staff members who review and preapprove the quality assurance sections of the plans and examine the reports from the external review organizations prior to the time that a recommendation is made for licensure.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Oklahoma regulations provide that HMOs are required to have an external review at least once every three years and more often if necessary. The Commissioner of Health can direct the Health Department to conduct the review or an organization approved by the Health Department can be responsible for the review. The Oklahoma Health Department has approved NCQA, Health PRO, Inc., JCAHO, and the Accreditation Association for Ambulatory Care, Inc. The MCOs' nominate the review organization they wish to have review them, but final selection is at the discretion of the Health Commissioner. Complaints are dealt with by Department staff.
Oklahoma currently licenses nine HMOs with a total of 266,000 members.

RHODE ISLAND

PLAN REVIEW

The regulation of managed care organizations in Rhode Island is divided between the Rhode Island Department of Health and the Rhode Island Department of Business Regulation. As in a number of the other states surveyed, the Department of Health is charged with reviewing MCOs' quality assurance programs to determine if the programs meet the state's laws governing quality assurance for MCOs. Currently, the Director of Health issues a certificate for satisfactory compliance with the regulations which allows the Department of Business Regulation to issue a license to operate the MCO. Any modifications to the MCO plans after licensure have to be sent to the Department of Health for review and approval of "material modifications" i.e., "any change to the information initially filed with the Department of Health including, but not limited to, systematic changes in provider networks and mechanisms for the management and control of the use of covered services by enrollees."

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL ONSITE REVIEWS

For MCOs that achieve licensure, Rhode Island, like Florida, requires that the MCOs be accredited by an external review organization acceptable to the Director of Health, within two years of initial licensure, or as deemed appropriate by the Department for those currently licensed as of January 1, 1994. Rhode Island does not include in its regulations a description of its process for approving accreditation organizations beyond the fact that the Director of Health has the authority to approve the accreditation organization. In practice, nationally-recognized MCO quality assurance accreditation organizations, such as NCQA, are routinely considered acceptable. All costs for accreditation are paid for by the MCO.

STATE ONSITE REVIEWS

Rhode Islands' regulations require that the Director of Health conduct examinations concerning the quality of health care services of any MCO that is licensed, not less than once every year, to determine continued compliance with the statutory and regulatory standards governing quality of care. Deficiencies found within the review are filed with the MCO by the Department and the MCO must present a plan of correction that is acceptable to the Director of Health. The expenses of the review are assessed against the MCO being examined and remitted to the Director of Health. The Director of Health has the right to hold hearings regarding MCOs that are in violation of the quality assurance standards. The recommendation and finding of the Director of Health with respect to matters relating to the quality of health care services provided by a MCO in connection with any decision regarding denial, suspension, or revocation of a license is conclusive and binding upon the Director of Business Regulation.

Rhode Island has three professional staff members who review the MCO applications and conduct the onsite state reviews. There are six licensed MCOs in Rhode Island with approximately 250,000 subscribers.

Funding for the MCO quality assurance reviews comes from application fees that are $3,000 per application. Rhode Island also has a process by which it bills MCOs for any time that is spent by employees on the review and approval process by using a software package "Timesheet."

NEVADA

PLAN REVIEW

Nevada regulates managed care organizations' qualify assurance programs through the Department of Human Resources' Health Division. The Department of Insurance issues the Certificate of Authority. Nevada's regulations and statutes which govern quality assurance of MCOs require that the Health Division examine each MCO application according to criteria stated in the regulations prior to granting a Certificate of Authority. Each applicant has to demonstrate that it has a quality assurance program that meets the state's criteria, that it has a method for evaluating the effectiveness of the quality assurance program and the services that are provided to members and that it includes a data collection program.

EXTERNAL ONSITE REVIEWS

MCOs in Nevada must submit to an external review organization examination of the quality of the health care services provided by a MCO. The criteria for approving an external review organization are that an organization must be: (a) the Federal Government for federal qualification as an HMO; (b) a group which is nationally recognized to provide accreditation of HMOs; or (c) a person approved by the state board of health. The board of health maintains a list of at least two persons whom the board has approved to assist the board in conducting the examination of an organization. Once the examination is completed, the results of the Health Division go both to the MCO and to the state board of health. The state board of health reports to the Commissioner of Insurance if the organization meets the quality assurance standards prior to the issuance of a Certificate of Authority. Each year, the MCO must also file an annual report to the Nevada Health Division which addresses its compliance with the state's MCO quality assurance regulations and statutes. Nevada's Health Division consists of one staff member assigned to MCO quality assurance review. Funding for the review process comes from state general funds. There are 12 licensed HMOs in Nevada with 278,201 subscribers.

SOUTH CAROLINA

PLAN REVIEW AND EXTERNAL ONSITE REVIEWS

South Carolina regulates managed care organizations exclusively through the South Carolina Department of Insurance. South Carolina's regulations governing quality assurance procedures for MCOs require that, following the review of the MCO application, each MCO must have a "Quality Assurance Review" by December 31, 1996, and at least every three years thereafter. The "Quality Assurance Review" must be performed by a qualified organization performing audits based upon similar criteria as set forth in the National Committee for Quality Assurance (NCQA) guidelines. Each HMO selects the external review organization and the cost of the

review is paid by the MCO. The Director of Insurance includes this review in his examination of every MCO. All the expenses of the examination for a recommendation for a Certificate of Authority under the regulations are assessed against the organization being examined and remitted to the Commissioner of Insurance. South Carolina has not adopted additional guidelines, other than what is in the law, for choosing external review organizations. Currently, South Carolina has 14 licensed MCOs and administers the regulatory program through a six person staff.

Conclusion

The states' regulations governing managed care organizations' quality assurance programs were also compared with the Commonwealth of Virginia's **Rules Governing Health Maintenance Organizations**, (State Corporation Commission, September 1, 1987). Virginia's regulations incorporate a section entitled "Grievance Procedure" and require a description of "procedures and programs established by health maintenance organizations to (1) assure both availability and accessibility of adequate personnel and facilities and (2) assess the quality of health services provided." The current HMO regulations and statutes in Virginia are heavily weighted toward regulating the financial obligations of an HMO, with only the reference made above to the quality of the health care services provided by the HMO or to systems that should be in place to monitor and evaluate the quality of health care services. It should be of benefit for the Virginia Department of Health to further explore its potential role in regard to quality assurance oversight of managed care organizations.

Comr. State Criteria

For Managed Care Quality Assurance Programs

	Corporate Accountability	Analysis of Outcomes of Health Care	Quality Assurance Evaluation Process	Collection of Health Care Data	Grievance Process	
	Written QA Program with Identifiable Organizational Accountability	Continuity and Coordination of Care Review	Medical record Audits	Types of Services Provided	Members Rights and Responsibilities	Quarterly-Annually Reporting of Types of Complaints and Remediation
	Medical Director	Access and Availability Study	Provider/ Member Satisfaction Survey	Subscriber Profiles	Internal Process for Complaint Processing	
	Annual QA Report to Board of Directors	Review of Underutilization and Over-utilization Tracking Data	Peer Review	Provider Profiles Including Specialists	Reporting Mechanism	
	Accountable Board Of Directors	Preventive Health Activities Analysis	External Quality Review		Informing Complainants of Decisions	
			Provider Credentialing Process		Levels of Appeal	
					Procedures for Quality Assurance Remediation	

Comparison of the Regulation of Quality Assurance in Managed Care Organizations Between Various States

State	Authority to Regulate MCOS Shared between State Health and Insurance Departments	State Has Statutes and Regulations Specifically Governing Quality Assurance in MCOS	Preapproval of MCOS' Quality Assurance Plans by Department of Health	Onsite QA Review of MCOS Required By An External Review Organization	Independent State Onsite QA Review of MCOS	State Process for Approving MCO External Review Organizations	MCO License or Certificate Contingent Upon State Approval Of QA Process
Pennsyl-vania	*	*	*	*	*	*	*
Vermont	*	*	*	*	*	*	*
Rhode Island	*	*	*	*	*	*	*
Oklahoma	Insurance Department Comments Only	*	*	*	—	—	*
Florida	*	*	*	*	*	*	*
Minnesota	Public Health Department has Sole Authority	*	*	—	*	—	*
Nevada	*	*	*	*	—	*	—
South Carolina	Department of Insurance has Sole Authority	*	—	*	—	*	*

APPENDIX M

ASSESSMENT OF CHAPTER 54 OF TITLE 38.2 OF THE CODE OF VIRGINIA

Appendix M: Assessment of Chapter 54 of Title 38.2 of the Code of Virginia

Chapter 54 of Title 38.2 of the Code of Virginia outlines the utilization review standards and appeals that are applicable to all entities in the Commonwealth who perform utilization review. This law was passed in 1995.

The American Accreditation HealthCare Commission/URAC has released utilization management standards that correspond to the provisions in Chapter 54. First published in 1991 and updated in 1994 and June 1997, these 35 standards provide companies with guidelines on developing utilization management programs. Georgia, Iowa, Maine, Nebraska, New Hampshire, and the District of Columbia currently require AAHC/URAC accreditation for licensure. Several other states recognize AAHC/URAC accreditation and exempt companies with this accreditation from certain state oversight requirements.

The National Committee for Quality Assurance (NCQA) has also published standards for accreditation of managed care organizations. These standards encompass guidelines for utilization management as well as guidelines for five other areas. Nine standards and their associated recommendations outline the NCQA evaluation process for UR programs.

In addition, Beth Hadley of the National Association of Insurance Commissioners (NAIC) was contacted. NAIC has produced a Utilization Review Model Act that established standards and criteria for the structure and operation of utilization review processes. They have also completed a review of all similar and related UR laws and regulations for each state. According to NAIC, currently only three states (Colorado, Maine, and Washington) have enacted legislation or regulations that follow the NAIC model or something very similar to it (April 1997 NAIC report). Most states, including Virginia, have legislation or regulations that are related to the NAIC model. Much legislation surrounding UR was discussed during the most recent state legislative sessions, as more states are debating the adequacy of current UR processes.

A comparison of Chapter 54 provisions and the NAIC model follows:

Response Times:	**Virginia**	**NAIC Model**
First Adverse Decision	2 working days	24 hours (telephone) 24 hours (concurrent) 5 working days (retrospect.)
Reconsideration	10 working days	1 working day
Appeal	60 working days	20 working days
Annual Submission of Appeals Required?	No	Yes
UR Criteria subject to regulatory review?	Yes	Yes
Clinical Peer required for adverse determinations?	No	Yes
Coordination required with Grievance Procedures?	No	Yes
Must consumer be notified of adverse determination?	No	Yes
Are UR criteria available to the consumer?	No	Yes
Peer review of appeal required by previously uninvolved peer?	Yes, except for expedited appeals	Yes for all appeals
Required coverage for emergency services authorized by participating provider or authorized employee?	Yes	Yes
Disclosure of UR appeals procedure required to be in EOC or other member materials?	No	Yes
Penalties for non-compliance?	No	Yes

Source: Virginia Department of Health

Methodology

In order to assess the adequacy of Chapter 54 of Title 38.2 of the Code of Virginia, a short survey was designed by the Department of Health Evaluation Sciences in consultation with the Bureau of Insurance and the Virginia Department of Health. The purpose of the survey was to assess the number of times that companies had used the provisions of Chapter 54, reasons for using or not using the provisions of Chapter 54, and willingness to provide information about Chapter 54 proceedings to the Bureau of Insurance. The instrument was faxed to all HMO plans (32) and the top 200 non-HMO indemnity plans based on premium volume. Plans were instructed to complete the survey and return it to the Bureau of Insurance. All survey information was entered into a database for analysis.

Analysis

We received usable responses from 106 non-HMO companies and 14 HMOs, resulting in a 52% response rate. The response rate is moderately high, especially given the short time allowed for data collection. Each question in the survey has been answered using responses from the companies, separated by type of plan. (*NA stands for not applicable.)

Activity Undertaken Pursuant to Chapter 54 of Title 38.2 of the Code of Virginia

1. Has your organization reconsidered any adverse decisions as provided in 38.2-5407 in the past 12 months?

Yes:	12 HMO 8 non-HMO	**No:**	1 HMO 62 non-HMO	**No answer/NA:**	1 HMO 36 non-HMO

If yes, how many: HMO range - 12 to 482 (mean 103)
Non-HMO range - 2 to 73 (mean 22)

2. Has your organization conducted any appeals of adverse decisions as provided in 38.2-5408 in the past 12 months?

Yes:	11 HMO 7 non-HMO	**No:**	3 HMO 63 non-HMO	**No answer/NA:**	0 HMO 36 non-HMO

If yes, how many: HMO range - 1 to 781 (mean 88)
Non-HMO range - 1 to 37 (mean 22)

3. Has your organization conducted any expedited appeals as provided in 38.5408 in the past 12 months?

Yes:	4 HMO 4 non-HMO	**No:**	10 HMO 66 non-HMO	**No answer/NA:**	0 HMO 36 non-HMO

If yes, how many: HMO range - 1 to 175 (mean 38)
Non-HMO range - 3 to 25 (mean 11)

4. Would you be willing to provide copies of the above proceedings (with names excised) to the Bureau of Insurance if requested?

Yes:	10 HMO 17 non-HMO	**No:**	2 HMO 19 non-HMO	**No answer/NA:**	2 HMO 70 non-HMO

5. If you HAVE NOT used the processes provided in Chapter 54, please state the reason:

Were not aware of its passage: No answers recorded

Have not had requests under this statute: 1 HMO, 12 non-HMO

Chapter 54 does not apply to the type of coverage written by the company (for non-HMOs only): 49 non-HMO

All appeals are handled under Chapter 43 of the Code of Virginia (HMOs only): No answers recorded

Dissatisfied with the Statute: 1 non-HMO

Other: 1 HMO, 6 non-HMO

No answer/Not applicable: 12 HMO, 38 non-HMO

6. If you HAVE used the processes provided in Chapter 54, please state how satisfied you were with the process.

Very satisfied:	1 HMO, 5 non-HMO
Somewhat satisfied:	2 HMO
Neutral:	10 HMO, 11 non-HMO
Somewhat dissatisfied:	1 HMO
Very dissatisfied:	
No answer/not applicable:	90 non-HMO

7. Do you inform your plan's providers about Chapter 54 and its processes?

Yes:	13 HMO 15 non-HMO	**No:**	0 HMO 17 non-HMO	**No answer/NA:**	1 HMO 74 non-HMO

If yes, how do you inform them?

HMOs (multiple answers were allowed)
Provider handbooks - 5
Send information to providers when applicable - 1
Provider newsletter - 3
Correspondence with provider - 2
Provider is given information (mode not specified) - 3
No answer - 1

non-HMOs
Informed in denial or appeal letters - 6
Informed in writing (type of letter not specified) - 3
Insured provided with information (mode not specified) - 7
Enrollment brochure or benefit booklet - 3
No answer/not applicable - 87

Conclusions: The survey used in this analysis was designed for educational purposes, not for rigorous scientific study. Therefore, we would not want to make generalizations about the use (or non-use) of Chapter 54 in Virginia. However, there are certain facts that merit added emphasis:

- In the non-HMO group, 49 companies reported that Chapter 54 does not apply to the type of coverage written by the company.

- In addition, 38 respondents stated they don't do utilization review, so they are exempt from the provisions of Chapter 54. These companies sent the survey back uncompleted and/or sent a letter explaining this. Being unfamiliar with all types of insurance products marketed in the state, we could not determine the accuracy of these statements.

- Twelve of fourteen HMO companies that returned surveys have used at least part of the processes of Chapter 54.

- Eight of 106 non-HMO companies that returned surveys have used at least part of the processes of Chapter 54. All eight have used 38.2-5407, seven of these eight have used 38.2-5408 for appeals, and four of these eight have used 38.2-5408 for expedited appeals.

- The majority of respondents who have used Chapter 54 were neutral about the process.

There are currently no regulations that are attached to the statute enacted under Chapter 54 of Title 38.2 of the Code of Virginia, which make it very difficult to enforce its provisions. In addition, as seen in the chart above, many of the provisions outlined by the National Association of Insurance Commissioners are not met by Chapter 54 as it stands.

APPENDIX N

MEMORANDUM OF AGREEMENT BETWEEN THE BUREAU OF INSURANCE AND THE DEPARTMENT OF HEALTH

APPENDIX N

MEMORANDUM OF AGREEMENT
BETWEEN
THE VIRGINIA STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE
AND
THE VIRGINIA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITIES REGULATION

WITNESSETH:

WHEREAS, the Virginia State Corporation Commission (hereinafter "the Commission"), Bureau of Insurance, 1300 East Main Street, Richmond, Virginia 23219 and the Virginia Department of Health (hereinafter "VDH"), Office of Health Facilities Regulation, 3600 West Broad Street, Suite 216, Richmond, Virginia 23230 are desirous of entering into an agreement for the purpose of memorializing the respective responsibilities agreed upon by the parties with regard to the regulation of Health Maintenance Organizations in the Commonwealth of Virginia, and how each party may best assist the other in carrying out such responsibilities; and

WHEREAS, the State Health Commissioner may examine the quality of the health care services of any Health Maintenance Organization or provider licensed by the Commission, as set forth in § 38.2-4315 of the Code of Virginia, as amended, and to examine the complaint system of a Health Maintenance Organization as set forth in § 38.2-4308 of the Code of Virginia, as amended; and

WHEREAS, the Commission is authorized to license Health Maintenance Organizations and to suspend or revoke the license of a Health Maintenance Organization pursuant to §§ 38.2-4301 and 4316, respectively, of the Code of Virginia, as amended;

NOW, THEREFORE, THE PARTIES HERETO AGREE TO THE FOLLOWING:

1. The Commission and VDH agree:

   a) The Commission shall be the official "lead agency" contact for the licensure and regulation of Health Maintenance Organizations;

   b) The VDH shall assist the Commission by providing both on-site and administrative review of quality assurance issues relating to Health Maintenance Organizations;

   c) VDH activities conducted under clause 1.b) shall be reimbursed through remittance to the State Health Commissioner by the subject Health Maintenance Organization, upon receipt of assessment invoices, for all actual costs and expenses of the Commissioner's quality of care or quality assurance reviews or investigations both on-site and during administrative review, in accordance with Va. Code §§ 38.1-403, 39.2-4308, 38.2-4315, and 38.2-4316;

d) The Commission and VDH shall each bear the costs of its respective responsibilities as agreed upon herein with regard to the regulation of Health Maintenance Organizations in the Commonwealth of Virginia, unless otherwise specifically provided by law; and

e) The VDH and the Commission shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by VDH to the Commission or by the Commission to VDH, and to follow the procedures regarding confidentiality of examination contents and results as prescribed by Article 4, Chapter 13, of Title 38.2 of the Code of Virginia, as amended or as otherwise prescribed by law.

2. The Commission agrees:

a) It will subject any Health Maintenance Organization that fails to reimburse the State Health Commissioner for expenses for quality of care or quality assurance reviews or investigations to any penalties otherwise available to the Commission;

b) It will ensure that necessary documents it receives, such as quality assurance plans and complaints dealing with quality of care, are submitted to the VDH in a timely manner;

c) It will assist the VDH in carrying out its responsibilities in the regulation of Health Maintenance Organizations by providing advice and expertise as requested, including permitting VDH personnel to participate in the Commission's Market Conduct Examinations of Health Maintenance Organizations, as mutually agreed; and

d) It shall effectuate any actions necessary to assure that its licensees comply with quality guidelines.

3. The VDH agrees:

a) It will, in a timely manner during the Commission's review period for initial application for licensure by a Health Maintenance Organization, review and approve Health Maintenance Organization complaint systems, and shall, in a timely manner, review such complaint systems for licensed Health Maintenance Organizations on an annual basis;

b) It will check for licensed providers who are not in compliance with licensure regulations, and who may yet be providing services to Health Maintenance Organizations, and shall report the results of such investigations to the Commission at the time of initial licensure and at such other times as VDH may determine to be appropriate;

c) It will assess the quality of health care services as such quality relates to providers contracting with each Health Maintenance Organization, such assessment to include, but not be limited to, the following:

1. i) A review of quality assurance and utilization review programs as part of the initial licensing process and as needed thereafter. VDH shall advise the Commission of the acceptability of such programs in a timely manner; and

ii) A review of criteria used by the Commission to determine that a Health Maintenance Organization has contracted with the appropriate number and kinds of providers to assure proper access to health care;

d) It will conduct administrative and on-site investigations of consumer and provider complaints regarding Health Maintenance Organization quality of care;

e) It will conduct on-site examinations, in coordination with the Commission, of the quality of health care services of Health Maintenance Organizations, to include:

i) The grievance/complaint system;

ii) Quality assurance plan/goals;

iii) Medical delivery system, including:

- Providers
- Services
- Access
- Availability
- Organization and Structure

iv) Advertising/Marketing;

f) It will assist the Commission in the revision of regulations upon request; and

g) It will assist the Commission in identifying non-compliant practices in violation of the Code of Virginia, as amended, and any applicable regulations adopted by the Commission.

THIS AGREEMENT shall become effective upon the date subscribed by the last signatory, and shall continue in force until terminated by either of the parties.

Amendments to this Memorandum of Agreement shall become effective upon written approval by both parties.

If any provision of this agreement or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

Date: 1/16/97

By: _____

Alfred W. Gross
Commissioner of Insurance
Bureau of Insurance
Virginia State Corporation Commission

Date: 1-16-97

By: _____

Randolph L. Gordon, M.D., M.P.H.
Commissioner
Virginia Department of Health

APPENDIX O

THE COMMONWEALTH'S ROLE IN THE PROVISION OF CONSUMER INFORMATION ON MANAGED CARE ISSUES

APPENDIX O: THE COMMONWEALTH'S ROLE IN THE PROVISION OF CONSUMER INFORMATION ON MANAGED CARE ISSUES

Appropriate information for consumers is the catalyst of the market place. Many public and private organizations collect data. However, producing credible information from these data that is usable to consumers is the challenge. Determining the appropriate role of state government in the fashioning of health information systems that are geared toward the interests of consumers is driven by a technological revolution that is fraught with both opportunities and perils. Users of the new "information age" expect ever increasing capabilities while at the same time demanding that essential safeguards protect their rights of privacy and confidentiality. In the context of these competing demands, VDH seeks to position itself as ensuring that the emerging information technologies not only enhance system efficiencies, but are also used effectively to improve the health care of Virginians.

Virginia is not the only state faced with this daunting task. In an article entitled "Health Information Systems and the Role of State Government" in the May/June 1997 issue of *Health Affairs*, Daniel N. Mendelson and Eileen Miller Salinsky provide a taxonomy and evaluation of state government efforts on the health information frontier. The range of state efforts which they identify, and the comparable efforts in the Commonwealth that are relevant to our emerging managed care responsibilities in state government include the following:

Providing Data

The collection of data by state government agencies is not a new phenomenon. More often than not, however, states have not had adequate mechanisms in place to integrate the multiple databases used by a variety of governmental entities. The result has been fragmented and duplicative systems which have precluded comprehensive and efficient analyses of available information. This situation is now turning around in many states with the availability of updated information systems and software packages that facilitate the integration of historically separate data sets, streamlined dissemination of health data, and more sophisticated analyses of the available information.

VDH has made data collection and dissemination a top priority through its Virginia Information System Integrated On-Line Network (VISION). The VISION system will allow the agency to fully integrate the different information systems within the health department, thereby enabling the user to analyze the relationships among data from multiple sources. VISION will assure timely access to comprehensive information about an individual and will also eliminate redundancy in data collection, not only for the health department, but also for hospitals and other providers. This emphasis on efficient utilization of information has enormous implications for all health care providers as they seek to improve the quality of Virginians' lives.

Disseminating Consumer Health Information

State health departments have established regulatory policies and monitored public health over the years by using such large data sets as hospital discharge databases, vital statistics, and communicable disease records. As these state agencies enter into relationships with new constituencies in the managed care era, they need to generate usable information from the data. States are also sharing information developed by the private sector about HMO performance measures, such as the Health Plan Employer Data and Information Set (HEDIS) which has been developed by the National Committee for Quality Assurance. Much of the newly available information is being made available over recently created electronic communication networks which are accessible via the Internet.

Another report that identifies what several other states are doing regarding the collection and reporting of outcomes data, and consumer satisfaction, is Jeanne M. De Sa's *The Market for Accountability: Measuring and Managing Health Plan Performance*. Published in November 1996 by the Alpha Center, the report's findings in these two areas are summarized in the table on the following pages.

This report observes that "state requirements that health plans produce and report outcomes information may not be sufficient to achieve quality assurance". Most state efforts to obtain data are voluntary, so that health plans may withhold or entirely fail to report outcomes without penalty. However, mandatory requirements raise other problems; health plans view them as intrusive and costly, and they challenge the usefulness of the state's capacity to use the required information. Consequently, the report concludes: "Most states are approaching quality improvement slowly and are focusing only on health plans that contract with Medicaid, state employees, or state-sponsored purchasing cooperatives."

The dissemination of public information about health care status in the Commonwealth is a role that has recently fallen to VDH through its health data reporting contractor, the Virginia Health Information (VHI). VHI is a nonprofit, tax-exempt health data organization that is mandated, to develop and implement health data projects that provide useful information to consumers and purchasers on health care providers including health plans, hospitals, nursing homes, and physicians. Like other states, Virginia collects health plan data on a voluntary basis. VHI's *Strategic Plan* discusses its initiatives that are related to the dissemination of information on health plans. These initiatives include publishing consumer satisfaction reports using HEDIS measures so that consumers can compare plans; publishing outcome data on obstetric deliveries using inpatient hospital data from the patient-level data base; and working with the U.S. Health Care Financing Administration to develop standard health plan identifiers for inpatient level data.

STATE	COLLECTION AND REPORTING OF OUTCOMES DATA	CONSUMER SATISFACTION
Colorado	State collects outcome data for Medicaid-participating health plans.	Medicaid agency conducts consumer satisfaction survey.
Florida	State collects selected HEDIS measures for Medicaid HMOs.	The state is administering a consumer satisfaction survey for health plans participating in CHPAs and Medicaid.
Iowa	State is developing CHMIS to collect claims-based data. Organized Delivery System (ODS) rules require reporting of HEDIS-based measures. Reviewing potential collection of Medicaid HEDIS measures.	State requires ODSs to assess and report on member satisfaction.
Kentucky	Health plans contracting with state purchasing alliance report on HEDIS measures.	State surveys enrollees in state purchasing alliance.
Maryland	HMOs are required to submit a subset of HEDIS to HCACC. HCACC issues annual report cards.	HCACC is required to survey consumers on health plan. satisfaction, and may survey participating providers.
Minnesota	Commercial HMOs report several HEDIS quality measures. State is reviewing potential collection of Medicaid HEDIS measures. Under Provider Information Pilot Study, MN Health Data Institute is directed to collect comparative data on quality from health plans. Not yet underway.	MN Health Data Institute conducted consumer satisfaction survey for health plans in 1995.

Missouri	Missouri Health Systems Partnership has developed a set of voluntary quality measures - MoHIS 1.0 - for health plans to report to state. Department of Insurance is mandated to publish consumer report cards in the future. Medicaid HMOs must submit modified Medicaid HEDIS measures to state	State conducts consumer satisfaction surveys for state employees. Medicaid will conduct consumer satisfaction surveys for those enrolled in managed care plans.
New Mexico	In 1996, health plans will submit NCQA HEDIS data in voluntary pilot. Submission is mandatory in 1997.	State may conduct consumer satisfaction surveys as part of health plan reporting for public use.
Oregon		Medicaid agency conducts consumer satisfaction survey. Relies on GHAA survey instrument.
Washington	Health plans participating in Basic Health Plan and state employees plan must submit HEDIS data to the state. State does not yet offer plan comparisons.	Medicaid conducts monthly satisfaction surveys.

Information in this table is taken from *The Market for Accountability: Measuring and Managing Health Plan Performance*, Jeanne M. De Sa, Alpha Center, Washington, D.C., November 1996.

APPENDIX P

SUMMARY OF ACCREDITATION ORGANIZATION STANDARDS

APPENDIX P: SUMMARY OF ACCREDITATION ORGANIZATION STANDARDS

Scott Daniels calls meeting to order, and explains that Kaiser will go at the top of the hour because they have to get back to Washington, D.C. This is followed by introductions.

Background is given to Kaiser from Scott: In HB 2785, we have to examine quality mechanisms and private accrediting bodies. Today, we are examining the descriptive nature of the accrediting bodies: URAC & NCQA, really exploring the relationship between state oversight and the private sector. Today we will be pressing one another about the gaps of private accreditation and the strengths of private accreditation along with the issue of deeming. Scott turns the meeting over to Ann Webber from the Virginia Health Quality Center, who will be acting as facilitator for the day.

Ann explains that the group will focus their energies on learning the mechanisms of accreditation and what happens within an HMO when they are going through it. With that framework, the presentations will be gone through quickly. We should focus on where the gaps are in private accreditation, where should the public sector come in, and what are the relationships between private accreditation and public oversight of managed care.

Presentation from Kaiser Permanente: Helen Stallings

Helen explained that she wanted to emphasize the difference between Managed Care Organizations and non-Managed Care Organization as they relate to quality management. Kaiser has closed systems. Kaiser has the opportunity to control and improve thier system. Currently, Kaiser is getting ready for a mock review, so she explained that she had to leave. Kaiser is fully accredited by NCQA, and would like to discuss what they do on a day to day basis to maintain NCQA accreditation.

Kaiser has internal Quality Improvement programs as well as external affiliations with NCQA. They have a medical directors quality review which is an internal review system. The Internal Quality Management process has 2 categories: quality assurance activities and quality improvement activities. There is also periodic monitoring of quality indicators: namely the HEDIS data . Kaiser gathers HEDIS measures above and beyond the standards. Pediatric immunization rates are one example. Their immunization targets are above the HEDIS standards. Also have peer review. Kaiser also has micro level peer review among physicians. They conduct periodic monitoring of service indicators by asking questions like; can people get us on the phone, can people get appointments, do they have enough Primary Care Physicians, etc. They look at unusual occurrence reporting and investigation, for example morbidity and mortality in hospital and ambulatory settings. They also look at nursing homes for morbidity and mortality statistics, and unusual experiences. They will not contract if they find questionable behavior. They spend time on credentialing doctors, facilities they contract with, and other providers (nursing homes,

hospice etc). They also credential hospices. These can all be considered quality assurance activities.

Regarding Kaiser's Quality Improvement activities: they don't just gather data, and they make an action plan if there are unusual circumstances. Some examples are nursing homes and pediatric immunization rates. They also identify best practices: they are a closed system. If one system is operating at 98% for pediatric immunization. and is exceeding everyone else, they go in and find out why. They can extrapolate these best practices to their network of affiliated providers.

Kaiser also conducts research on new methodologies: They have the benefit of adopting new technologies. Some examples are improved biopsies for suspicious breast lesions. They conducted an in-house controlled study on the efficacy of this procedure. The procedure demonstrated the same kind of diagnostic reliability and validity as did the traditional surgical methods. Kaiser was able to learn about it, test it and adopt it.

Question : What is the process and criteria KP uses to evaluate new technology?

KP: The criteria is based on Permanente medical group and the Kaiser Foundation. It is the Kaiser doctors' job to determine medical appropriateness. It is the health plan's job to work with doctors in looking at economics. If the most efficacious treatment is most expensive, then they use it. If it is equally expensive and efficacious, then they devise clinical practice guidelines to examine it appropriateness, through research.

Question: When do the economic factors override the medical factors? How do they interrelate?

KP: Currently Kaiser is looking at issue of dexascans for treatment of osteoporosis. They are very expensive. Clinical evidence was not there a few years ago. Now it looks like dexascans with certain populations will slow the progression osteoporosis. A doctor's group came out and said they wanted this procedure to be covered for this specific population. The health plan now pays since doctors establish policy. For this group, this is the standard of care.

Question: How do you communicate the criteria to enrollees and to the provider community?

KP: When it is approved, clinical practice guidelines are distributed to providers. They have continuing education. Kaiser also puts guidelines in electronic format. For members, they have numerous member education strategies. One is an enrollee magazine. They also have a healthwise handbook mailed to every subscriber. They have posters in the medical centers, health education classes available to members, and a website.

Question: What happens if a doctor wants to recommend a procedure for a patient that doesn't quite meet criteria, what are the grievance procedures?

KP: If a doctor says its appropriate, the patient, gets the procedure. If a doctor orders too many procedures, then they investigate whether the doctor has been effectively using health resources. If overutilization is the case, then corrective action plans will be taken. If they do not adhere to the corrective action plan, then they will be terminated.

Question: How do you train the people doing the review, and can you describe the total appeals process?

KP: We have 2 types of reviewers: UR nurses in the hospitals and doctors make all decisions regarding denials. Any nurse judgment is referred to a doctor. There are 2 types of appeals: one by doctors and one by members. We issue a statement to a member if care is no longer medically appropriate. They are told at the time how to appeal. There are different levels of appeal. Medicare members have a different track. People can appear in person to appeal. Regarding physician appeals, KP doctors always determine medical appropriateness. Affiliated network doctors can appeal through physician managers. All decisions are determined by physician managers.

Question: Can you bring your lawyer to an appeal? What is the final level of appeal?

KP: Yes, you can bring one representative. If someone is incapacitated, they can bring a lawyer. The final level is the VP for Special Services. He is from the Health Plan. Physician advisors are on all committees. In Kaiser, doctors determine appropriateness and the health plan issues denials and hears appeals.

Question: It is my understanding that the final decision for appeal cannot be made by an employee of the plan. A panel of doctors who are not employees should be on the panel.

Note: At this point, there was confusion over Kaiser's compliance with Chapter 54 of the Code of Virginia. Clarification has been recently submitted and is attached.

KP: It is my understanding that for physician appeals, there has to be an external group that would review the case, not the member physicians.

Study Group Member: The law says that the appeal can be brought by the enrollee or their representative.

KP: We have another physician group lined up and ready for cases in Virginia. Everything they talk about is addressed by NCQA standards.

NCQA Response: Kaiser does have an established standard on everything they talk about. Just to point out other Quality Improvement activities they do use on a daily basis; new technologies and continuing education. As a closed system they can require participation in Continuing Medical Education. They credential people in procedures, new physician mentoring, use of technology (electronic medical information system). This enhances continuity of care. Medical records do not go out on the internet. When I'm not NCQAing, my job is manager of clinical guidelines: these are used to define the standard of care, define quality of care based on research, not opinion. We have preventive and chronic care guidelines. If a physician is not in compliance with recommendations of a guideline and the patient population does not have outcomes they want, then corrective action is employed.

Presentation by National Committee on Quality Assurance: Steve Lamb

The New York Times this morning reads " Pioneering State for Managed Care considers Change : California Thinks Again". Virginia is ahead of California: they are only now appointing a commission like this. It is necessary to keep in mind how old some of these regulations are. NCQA standards are updated on an annual basis : the committee has consumers, providers, and other groups. Federal standards are not updated (not since 1973). One of the advantages of the private sector is flexibility the public sector does not have. HEDIS 3.0 is a collection of standardized performance measures: these are separate from our accreditation criteria. HEDIS sets standardized measures: member satisfaction rate, etc. The group that compiled it included organized labor, purchasers, and federal and state government.

HCFA says if you want to do business with them, then you have to send HEDIS data to NCQA. That allows HCFA to look at performance across regions and across states and do regional comparisons. They can tell if some areas of the country have cut back too far. NCQA accreditation standards cover six areas: Quality Improvement, Credentialing, Utilization management, Members rights and responsibilities, Medical records and Preventive health services. More and more states are saying if NCQA is doing the accrediting, let's take advantage of that.

There are now about 11 states that say as a condition of licensure you have to have NCQA accreditation. In those states, the regulators from the state departments of Health go with them on their review. Their teams are composed of physicians. Surveyors are nurses or people with a Masters in Public Health or both, but the core is comprised of physicians. This gives the state access to a set of standards that is updated regularly. NCQA also accepts public comments on their standards.

Results of their accreditation reviews are made public. For example, a person can go to the website and observe all the reviews conducted in the past 2 years: They have Accreditation Summary Reports for each Managed Care plan, and plans are ranked relative to the last 50 reviews.

Question: Are your criteria on the web also?

NCQA: Criteria are available to the public also. You can purchase the manuals and guidelines. You would want to buy the surveyor guidelines.

NCQA also has a couple of other accreditation programs. Many Managed Care Organizations have carved out Mental Health Services into what are called MBHOs; managed behavioral health organizations. NCQA has an accreditation program with an entirely different set of standards for those MBHOs. They also have an accreditation program for CVOs; credentialing verification organizations. There is some duplication which has been caused with their standards because many physicians contract with a number of MCOs. Many of these CVOs have sprung up, and most are because local medical societies choose to do this for their members. They have also come out with standards for the accreditation of Physician Organizations.

The notion of deeming is growing very fast. The House and Senate are currently passing the budget amendment. It states that where appropriate, the Secretary of Health and Human Services should be able to take advantage of the work of the private sector. Many other states have said if you want to be licensed you need an external quality review. States in the role of purchaser have also become more aggressive. You're finding states that have said that if you want to do business with us as a state, you've got to be NCQA accredited. It allows states to better focus their resources.

Question: Where are the gaps between state and private accreditation, and where do you see the state role coming in?

NCQA: The majority of reviews are annual. We are moving to a performance informed accreditation program. Our biggest gap is we don't accredit every organization. Many states have asserted that if the entity is not NCQA accredited, that tells them something about the organization.

Question: How far do states go when they establish the law?

NCQA: The better approach is to allow the regulators to decide, as opposed to legislating that.

Question: What is the minimum size an Managed Care Organization has to be in order to pursue NCQA?

NCQA: Population by itself is not a determinant. We do not set a membership level. We usually don't look at MCO unless they have been in existence for 18 months. A small plan will be challenged in the market.

Question: Will size be a barrier into the market?

NCQA: We recommend a phase -in

Question: What does it cost for NCQA accreditation?

NCQA: For a plan with 50,000 members, the base price is $36,000

Question: What happens if an HMO delegates to an MBHO that is not accredited?

NCQA: We apply Managed Care Organization standards to MBHO delegation, so it is easier for an MBHO to go through accrediting process. We also have

credentialing standards for providers. We don't look through Dental HMOs persay. They credential within the organization, but not the group.

If a plan is not meeting one of the standards, they have to make progress doing what they missed.

We have a work group now internally looking to developing standards for PPMs; pharmacy management companies.

Question: Can you lose your accreditation sometime?

NCQA: Yes.

NCQA: The Mergers & Acquisitions Dept. If there are two plans that are accredited that are merging, we go on-site and do a survey. If they received a high number of consumer complaints in one area, then they investigate the review manager thoroughly. We also have a member satisfaction segment. Plan has to show they are improving member satisfaction through HEDIS.

Plans have to have an outcome: Quality Improvement results. These results are improvements in consumer satisfactions. Most use a HEDIS measure to do that.

Question: Is there a criteria for sentinel events?

NCQA: Could be a number of things: significant change in enrollment, regulatory action.

Question: What is the timeline for adhering to regulations after a violation?

NCQA: Plans have 30 days from the notice of a regulatory violation to fix it.

Question: Can an HMO be fully accredited and still be practicing abhorrent practices? For example, routine denials.

NCQA: It would be a fundamental failure of the UR review process if that were to occur. We look at a random sample of UR denials. We also do a physician satisfaction survey.

Question: There are HEDIS measures that plans are putting in place. Is there a list of quality outcomes that NCQA requires?

NCQA: Yes, they include : What does the person report to be their own health status? Are they pleased with their service? Mortality and morbidity rates are not sophisticated enough to assess outcomes. Plans need to break down how their physicians are paid also.

Question: Through what source does HEDIS measure quality of care?

NCQA: There are two ways we approach quality of care. One is through the accreditation standards. For example if a provider leaves the network,

the HMO has to make sure the patient receives a similar provider.

Presentation by the Utilization Review Accreditation Commission - Guy D'Andrea

URAC was founded in 1990 as the Utilization Review Accreditation Commission. As they have grown, they have expanded the scope of their activities. The decision was made to adopt a name that reflected that broad scope of activities. Their mission was to bring some standardization to the Utilization Review industry. The Utilization Review industry was under criticism for inconsistency, difficulty for patients and providers to navigate, and not fully incorporating medical clinical thinking into the decision making process. The industry saw the writing on the wall and formed this organization to set standards for the industry. They recognized that for the process to be successful and to have any kind of acceptance, there had to be a broad based involvement in the process so that all the various interests were represented. So at that time, URAC had a broad-based membership. Its membership represented the entire constituency of interested parties. Members included individuals in the provider community, consumers, regulators, business and labor unions. The idea was that all these groups coming together could come up with standards applicable to all of them.

The first UR review standards were released in 1991 and were updated in 1994. To date URAC has completed a total of 500 accreditation reviews of Utilization Review management programs. That is their core business. They have also begun some new accreditation programs that reflect the growth of the industry. They have a program for networks; meaning mostly PPOs. They have accredited 21 PPOs in the country to date. They also have standards for Worker's Compensation UR Management.

In terms of putting their standards together, when URAC develops standards, they bring in specialists from the field. They have a committee process which is consensus driven. They develop a draft set of standards, which are then sent out for public comment. They do testing of the standards, and then send them out for final revision and approved by the Board of Directors. They historically have updated standards every three years. Once approved, then the standards are available for entities to apply for accreditation. The primary reason plans apply for accreditation is purchasers in the market place. Purchasers want to have some demonstration that a Managed Care Organization is committed to fair practices and quality. The secondary reason is for self-improvement. The third reason is for regulatory compliance efficiency. That starts to grow where you have multiple states that mandate private accreditation. The states may actually mandate as part of a regulatory requirement.

After an entity applies for accreditation, they submit an application which documents their compliance that is listed in the URAC guidelines. URAC conducts an internal review of that documentation, and then there is a period of dialogue between URAC review staff and the applicant. Once there is a certain level of comfort, then there is a site visit. Once that is complete, the reviewer makes a recommendation for accreditation to the URAC accreditation committee, who then can decide what they want to do. Finally, assuming it is approved, it goes to

the executive in charge of accreditation at URAC. URAC does involve all of their membership in their accreditation committee.

Guy D'Andrea displayed a list of states that URAC has affiliation/relationships with. Some have either suggested or mandated URAC accreditation. Deemed status is when a state gives a plan the option of getting private accreditation or going through the state regulatory process. Mandated status is when the review is a condition of state licensure. There are nuances in each of those broad categories.

Question: Do states use your standards of accreditation? Are state standards stricter or less strict? Are they at least as comprehensive as URAC's?

URAC: Most states that deem us have their own set of standards, but an organization that is accredited by us is not subject to the state standards. There are variations. Not all state requirements are encompassed in our standards. In some cases, the state conditions are more stringent than URAC standards.

Question: Have you ever done a side by side comparison of NCQA and URAC standards?

URAC: In the broad strokes, the standards are very close. We get into a little more detail about time frame and levels of review. In general I would say they are compatible, but not identical.

NCQA: There was a cross study done by BCBS but it is somewhat out of date

Question: When you're talking about deemed status, are you saying they are considering it deemed for UR organizations or UR components of MCOs.

URAC: It varies from state to state. Some states have stand-alone UR organizations.

Question: In your reviews, do you ever do any analysis of whether the state requirements are being met?

URAC: Certain states have UR reviews above and beyond ours. In certain states we do review their standards as well.

Question: Is your accreditation 2 years and are there different levels?

URAC: Yes, we have 2 year accreditation, and it is a yes or no decision. There are no different levels.

Question: One article I read said you are focusing on MCOs not eligible for NCQA accreditation. Can you explain that a bit?

URAC: We have developed standards for UR and networks (meaning PPOs). We developed standards more suited to the PPO industry. We found the industry is quite diverse. The cream of the crop apply for our standards.

Questions for Both

What is your organization's official position on whether or not states should make your accreditation deeming for mandated?

NCQA: The relationship we have with states is more beneficial to them than to us.
URAC: The only caution we would have would be to not tie the state's hands. The licensure decision should remain with the regulator.

URAC: Our PPO standards look at credentialing and member protection etc. The other end of the spectrum are PPOs that contract physicians. About 1/2 of the states don't even try to regulate the arrangements.

NCQA: We are holding HMOs at very high standards, but there are more people that are in PPOs. Before contemplating a whole new set of regulations for HMOs, we would like to survey the PPOs in Virginia and what kind of medical management techniques they are using. We do not want to focus on one part.

APPENDIX Q

SUPPLEMENTAL RESEARCH

Association of Managed Healthcare Organizations – April, 1997
Quality Assessment/Improvement (QA) Survey RESULTS – 44 of 189

1. Please indicate which of the following products your organization offers. (Please indicate all that apply.)

	YES	NO	# of States Offered
• **Preferred Provider Organization**	42 95%	0	1-50 (11 - 1; 5 - >45)
• **Exclusive Provider Organization**	21 48%	9 20%	
• **Health Maintenance Organization**	18 41%	11 25%	
• **Point-of-Service**	22 50%	4 9%	
• **Workers Comp**	21 48%	5 11%	
• **Behavioral Health**	18 41%	7 16%	
• **Open-Access**	12 27%	8 18%	
• **Integrated Delivery System**	10 23%	5 11%	

- **Other – Community Prod 1 State; Utilization Management; Personal Injury Protection (PIP) network access, medical management PPO; Claims Repricing, Utilization Management;**

2. Please indicate whether your organization offers products for the following groups.
   - **Medicare** **13; 30% YES 31; 70% NO**
   - **Medicaid** **6; 14% YES 38; 86% NO**

3. Does your organization have a written QA plan? ✓
   39; 89% YES 5; 11% NO
   No - However, the networks we work with do.
   If yes, how often is it updated?
   38 - Annually or more often
   1 - Every 3 Years

4. Does your organization have a formal QA program? ✓
   37; 84% YES 7; 16% NO
   2 of No answers have networks with formal QA programs.

5. Is QA a separate budget item?
   12; 27% YES 30; 68% NO **1 No Response**
   If yes, what is the amount budgeted for the current year?
   Most did not report - 1 indicated 6% of budget - 2 others reported $154,000 and $185,000.

15. Do you routinely survey providers regarding access issues and other quality indicators?
26; 59% YES 17; 39% NO (1 - Planned)
If yes, how frequently?
24 Annually or more often - 2 Every two years

16. Do you have a formal provider credentialing program?
44; 100% YES
If yes, does it credential:

- **MDs?** **41; 93% YES 1; 2% NO**
- **DOs?** **39; 89% YES 2; 5% NO**
- **DPMs?** **35; 80% YES 4; 9% NO**
- **Podiatrists?** **35; 80% YES 3; 7% NO**
- **Dentists?** **17; 39% YES 20; 45% NO**
- **Chiropractors?** **29; 66% YES 11; 25% NO**
- **Hospitals?** **37; 84% YES 3; 7% NO**

17. Do you structure your credentialing to comply with any of the following organizations' standards?

- **NCQA** **32; 73% YES 8; 18% NO**
- **URAC** **20; 45% YES 8; 18% NO**
- **JCAHO** **15; 34% YES 14; 32% NO**

18. Do you delegate credentialing to other entities (IPA, PHOs, other networks)?
23; 52% YES 21; 48% NO
(Most common response - delegate to our networks)
If yes, of your total panel what percent are:
Directly Credentialed?
Wide variations - Only 2 directly credential 100%
Credentialed Through Delegation?
Wide variations - Only 2 directly credential 100%

19. Do you have a formal provider recredentialing program?
41; 93% YES 3; 7% NO **Yes - Our networks do.**
If yes, how frequently?
All 2 years or less.

20. Have you rejected providers for quality considerations?
39; 89% YES 3; 7% NO **2 No response** **Yes - Our networks do.**
If yes, what percentage?
Range from <1% to 5%

21. Have you terminated providers for quality considerations?
37; 84% YES 6; 14% NO **1 No Response**
Yes - Our networks do.
If yes, what percentage?
Range from <1 to 3

22. Do you employ or contract for a Medical Director?
43; 98% YES 1; 2% NO
Yes - Our networks do.
If yes, please indicate what percentage of full-time he/she is used.
13 Full-Time
Rest Part-Time

23. Do you have a full or part-time director of QA?
32; 73% YES 11; 25% NO 1 No Response
Yes - Our networks do.
If yes, please indicate percentage of full-time.
18 Full-Time
Rest Part-Time

24. Do you have standards regarding access to care?
35; 80% YES 8; 18% NO 1 No Response
Yes - Our networks do.
If yes, please indicate areas addressed.
- **Network Size** **33; 75% YES 2; 5% NO**
- **Provider Type Distribution** **33; 75% YES 2; 5% NO**
- **Access to Appointments** **28; 64% YES 6; 14% NO**
- **Driving Times** **28; 64% YES 6; 14% NO**

25. Are you actively involved in health promotion/preventive care activities?
28; 64% YES 15; 34% NO 1 No Response

26. Do you offer a patient appeals/grievance process?
41; 93% YES 3 No Response

27. Do you offer a provider appeals/grievance process?
41; 93% YES 1; 2% NO 1 No Response

28. Are you accredited by the any of the following?
- **URAC** **13; 30% YES 26; 59% NO**
- **JCAHO** **3; 7% YES 35; 80% NO**
- **NCQA** **2; 5% YES 36; 82% NO**
- **AAPI** **1; 2% YES 35; 80% NO**
- **Other (Please specify) - NCQA approves carriers/HMOs who delegate to us; Currently preparing for NCQA; NCQA site visit schedule for 1998; Preparing for NCQA - July, 1998; Licensed by state where applicable; None of these organizations credential specialty HMOs or PPOs for managed vision care;**

29. Are you considering initial or additional accreditation?

29; 66% YES 12; 27% NO 2 No Response

If yes, please indicate which organization(s).

- **URAC** **13; 30% YES 5; 11% NO**
- **JCAHO** **7; 16% YES 9; 20% NO**
- **NCQA** **21; 48% YES 7; 16% NO**

If no, please explain.

None of the above organizations accredit chiropractic organizations.

Not priority at this time, mainly due to PA state regs re: delegation by MCOs who are accredited.

Appendix Q

SPECIAL ARTICLES

A NATIONAL SURVEY OF THE ARRANGEMENTS MANAGED-CARE PLANS MAKE WITH PHYSICIANS

MARSHA R. GOLD, SC.D., ROBERT HURLEY, PH.D., TIMOTHY LAKE, M.P.P., TODD ENSOR, AND ROBERT BERENSON, M.D.

Abstract *Background.* Despite the growth of managed care in the United States, there is little information about the arrangements managed-care plans make with physicians.

Methods. In 1994 we surveyed by telephone 138 managed-care plans that were selected from 20 metropolitan areas nationwide. Of the 108 plans that responded, 29 were group-model or staff-model health maintenance organizations (HMOs), 50 were network or independent-practice–association (IPA) HMOs, and 29 were preferred-provider organizations (PPOs).

Results. Respondents from all three types of plan said they emphasized careful selection of physicians, although the group or staff HMOs tended to have more demanding requirements, such as board certification or eligibility. Sixty-one percent of the plans responded that physicians' previous patterns of costs or utilization of resources had little influence on their selection; 26 percent said these factors had a moderate influence; and 13 percent said they had a large influence. Some risk sharing with physicians was typical in the HMOs but rare in the PPOs. Fi six percent of the network or IPA HMOs used capitat as the predominant method of paying primary care phy cians, as compared with 34 percent of the group or st HMOs and 7 percent of the PPOs. More than half HMOs reported adjusting payments according to utiliz tion or cost patterns, patient complaints, and measures the quality of care. Ninety-two percent of the network IPA HMOs and 61 percent of the group or staff HMOs r quired their patients to select a primary care physicia who was responsible for most referrals to specialist About three quarters of the HMOs and 31 percent of th PPOs reported using studies of the outcomes of medic care as part of their quality-improvement programs.

Conclusions. Managed-care plans, particularly HMC have complex systems for selecting, paying, and monito ing their physicians. Hybrid forms are common, and th differences between group or staff HMOs and network IPA HMOs are less extensive than is commonly as sumed. (N Engl J Med 1995;333:1678-83.)

UNDER managed care, the financing and delivery of health care are organized by a single entity. Managed-care plans are classified as health maintenance organizations (HMOs), preferred-provider organizations (PPOs), or various mixes of the two.[1] There are two major forms of HMO: group-model or staff-model HMOs and network or independent-practice–association (IPA) HMOs. Both types are usually at risk for the costs of care and therefore often control costs by requiring patients to be referred to specialists by primary care doctors. The doctors in network or IPA HMOs are usually in independent practice. A PPO, in contrast, consists of a group of doctors who agree to provide services to the plan's patients for discounted fees. Although managed-care plans are growing rapidly in the United States, they are controversial among physicians, who are concerned about their intrusion into medical practice.[2-4] Despite important studies of managed care,[5-7] there is relatively little information on the arrangements managed-care plans make to recruit, pay, and monitor physicians.[8] Much more is known about group or staff HMOs than about newer types, such as network or IPA HMOs and other forms of managed care, which account for much of its recent growth.[6,7,9] In contrast to group or staff HMOs, which use physicians in fully integrated group practices, network or IPA HMOs use community-based physicians in private practice and thus may intrude more on physicians' practices. The early network or IPA HMOs were loosely structured. Fee discounts and utilization review were the main new features. Although many people assume that this loose structure continues today,[10,11] the assumption remains controversial.

To learn more about the arrangements different plans make with physicians, the Physician Payment Review Commission sponsored a telephone survey of managed-care plans, conducted in 1994 by Mathematica Policy Research.[12,13] The survey covered the recruitment of physicians, compensation and financial incentives, and nonfinancial influences on care, including oversight of quality, profiling, practice guidelines, and utilization review.

From Mathematica Policy Research, Washington, D.C. (M.R.G., T.L., T.E.); the Department of Health Administration, Medical College of Virginia, Virginia Commonwealth University, Richmond (R.H.); the Robert Wood Johnson Foundation IMPACS Program/CHPS, Georgetown University, Washington, D.C. (R.B.); and the National Capital Preferred-Provider Organization, Washington, D.C. (R.B.). Address reprint requests to Dr. Gold at Mathematica Policy Research, Suite 550, 600 Maryland Ave., SW, Washington, DC 20024.

Supported by a contract between the Physician Payment Review Commission and the Medical College of Virginia and Mathematica Policy Research. The views expressed in this article are those of the authors and not the Physician Payment Review Commission. Dr. Berenson is medical director and cofounder of the National Capital Preferred-Provider Organization, which was not included in this study.

METHODS

Samples and Response Rates

We restricted the survey to HMOs and PPOs. We used a two-stage selection process in which 20 market areas were chosen, and then a sample of plans operating in these areas was selected.[14] Plans were defined as entities in particular market areas rather than parent corporations. In the first stage, the 54 largest metropolitan areas (where 86

cent of HMO enrollees reside) were stratified according to size der 1 million people or 1 million or more) and managed-care pen- ation (under 30 percent, 30 to 49 percent, or 50 percent or more). thin these strata, individual market areas were selected at random. e probability that any given metropolitan area would be selected s proportional to the size of its managed-care enrollment.

In the second stage, we selected one sample each of group or staff MOs, network or IPA HMOs, and PPOs. An HMO was classified group or staff plan or as a network or IPA plan, and HMOs with re than one type of model were classified according to which type dominated, as reported in the Group Health Association of Amer- *National Directory of HMOs*.[14]

Although HMOs and PPOs enroll about the same number of peo- nationwide, we limited the PPO sample to 30 percent of the total, ause PPOs have less diverse and less developed managed-care fea- es than HMOs. We established the size of the group or staff HMO mple and the network or IPA HMO sample on the basis of their ares of total nationwide HMO enrollment (39 and 61 percent, re- tively). The probability that a given plan would be selected was erally proportional to the size of the plan within its market. How- r, we did seek a minimum of one plan of each type from each mar- Selecting the PPOs was complicated by the absence of a good list PPOs from which to sample and by the need to obtain preliminary rmation by telephone.

Although the original sample consisted of 146 plans, the effective mple was 138 plans, because 5 also offered HMO products and thus re already in our study through the HMO sample and 3 had ged. The overall response rate was 78 percent: 78 percent for the up or staff HMOs, 83 percent for the network or IPA HMOs, and percent for the PPOs (which were surveyed last). National data w that the HMOs that responded were generally similar to those did not, except that the response rates were lower (17 of the 31 MOs, or 55 percent) for the plans owned by commercial insurers.

Questionnaire

All plans received the same questionnaire, which contained more an 300 items. It was developed on the basis of a literature review advice from a panel of researchers and experts in the delivery of aged care.

The plans were surveyed between June and September 1994. Each ived a letter on Physician Payment Review Commission letter- ad along with a list of panel members and letters of endorsement m industry trade associations. The respondents were senior clinical agers designated by the chief executive officers of the plans. Be- se of the length of the questionnaire, we allowed up to three re- ndents, whose areas of knowledge corresponded to the three ma- areas surveyed.

Sources of Error and Bias

Our results are limited in that they are based on what the respond- said rather than on an audit of what they do, how well they do it, how strongly the plans' arrangements influence the practice of sicians. Any bias in the results probably arises from overreporting managed-care approaches, especially those regarded as desirable. The findings are reported according to the type of plan. Because of small sample, we mention only differences that are large and that a consistent trend across similar variables. Statistically signifi- t differences were determined with use of the chi-square test.[15] aller plans are underrepresented relative to their number but are underrepresented relative to their share of national managed-care ollment.

Results

Table 1 shows the characteristics of the 108 study lans. Together they enrolled 33.5 million people; 15.2 illion of these were in HMOs, representing 35 percent the national HMO enrollment of 41.3 million people hen the sample was selected. The plans usually had at ast 100,000 members, and often more than 250,000.

Table 1. Characteristics of 108 Managed-Care Plans.

Characteristic	All Plans (N = 108)	Group or Staff HMOs (N = 29)	Network or IPA HMOs (N = 50)	PPOs (N = 29)
		percent		
Enrollment*				
<50,000	17	34	12	7
50,000–99,999	15	14	14	17
100,000–249,999	24	31	20	24
≥250,000	44	21	53	52
First year of operation				
Before 1970	10	34	0	3
1970–1979	26	41	30	0
1980–1984	24	14	18	45
1985–1989	35	7	48	41
1990 or later	4	3	2	10
For profit	59	34	74	72
Ownership				
Commercial insurer	8	7	10	7
Blue Cross–Blue Shield	16	10	20	14
National HMO or managed-care company	24	34	28	7
Other†	52	48	42	72
Federally qualified HMO‡	64	83	57	—
Managed-care penetration in market§				
Low (<30%)	28	24	26	34
Medium (30–49%)	23	24	20	28
High (>49%)	49	52	54	38
Market size				
<1 million	19	17	16	28
≥1 million	81	83	84	72

*Plans were asked to provide enrollment figures according to the benefit plan offered. For PPO and other point-of-service benefit plans, plans could provide the number of persons covered or the number of subscribers. To convert the number of subscribers to the number of persons, we used the ratio of 2.2 persons per subscriber, which is published by the Group Health Association of America.

†Other includes other national companies, independent owners, joint ventures, physician owners, community or regional groups, hospitals, and other nonprofit groups.

‡Federal qualification is generally not applicable to PPOs, except for the few that offer HMO products.

§Market penetration is the percentage of the area's population enrolled in managed-care plans.

Nearly all had been formed before 1990, and many before 1980. For-profit plans accounted for 59 percent of the sample and for about three quarters of the network or IPA HMOs and the PPOs.

Forming and Maintaining the Network

When asked which of three statements best characterized their policy on selecting physicians, most respondents chose "careful selection" (71 percent) rather than "prune later" (18 percent) or "as broad as feasible" (11 percent). Some plans (38 percent) were subtracting physicians ("tightening" the network), and others (43 percent) were adding physicians ("widening" the network). The group or staff HMOs were somewhat more likely to report widening their networks (51 percent) than the network or IPA HMOs (42 percent) or the PPOs (34 percent).

Table 2 summarizes the procedures used in recruiting physicians. When selecting physicians, the group or staff HMOs tended to have more demanding requirements than the other types of plan. Ninety percent of group or staff HMOs, but only 48 percent of the network or IPA HMOs and 41 percent of the PPOs, required board certification or eligibility. Both types of HMO were more

Table 2. Procedures Used by Managed-Care Plans to Recruit Physicians.

PROCEDURE	ALL PLANS (N = 108)	GROUP OR STAFF HMOs (N = 29)	NETWORK OR IPA HMOs (N = 50)	PPOs (N = 29)
		percent		
Selecting physicians				
Require board certification or board eligibility*	57	90	48†	41†
Require privileges at network hospital or ability to obtain them	82	86	88	69‡
Require agreement to take predetermined number of patients or not to practice outside plan§	37	48	48	7‡¶
State that the effect of previous costs or utilization patterns on the decision was large	13	4	18‖	14
Contracting with physicians				
Verify license and credentials**	100	100	100	100
Consult National Practitioner Data Bank, sources on substance abuse, or both	92	86	94	93
Visit physician's office, review facility, and screen care through medical records††				
Do all three	43	38	66‖	7‡¶
Do none of these	27	34	8†	52¶
Review quantitative data from indemnity claims, hospital-discharge data, or both	37	24	38	48‖
Meeting four criteria for orienting new physicians‡‡	30	69	22†	3‡‡

*Other plans may allow exceptions.

†P<0.01 for the comparison with group or staff HMOs.

‡P<0.10 for the comparison with network or IPA HMOs.

§Only 100 plans responded (27 group or staff HMOs, 45 network or IPA HMOs, and 28 PPOs).

¶P<0.01 for the comparison with network or IPA HMOs.

‖P<0.10 for the comparison with group or staff HMOs.

**Only 102 plans responded (25 group or staff HMOs, 48 network or IPA HMOs, and 29 PPOs).

††Because they are much more likely to hire than to contract with physicians who practice in their facilities, group or staff HMOs may find these steps unnecessary or address the underlying concerns in different ways (e.g., by contacting references).

‡‡The four criteria are as follows: plan has orientation meetings specifically for medical staff, 75 percent or more of physicians participate, top management is involved, and less than 75 percent of time is devoted to administrative issues. Of all plans, 5 percent met none of the criteria, 17 percent one, 23 percent two, 26 percent three, and 30 percent four.

likely than the PPOs to require that new physicians either have privileges at network hospitals or be able to obtain them. Both types of HMO were also more likely than the PPOs (48 percent vs. 7 percent) to require physicians to provide care for a predetermined number of patients or to practice only within the plan.

A minority of the plans (37 percent) used quantitative information about physicians' performance and practice style in selecting new physicians. However, 63 percent of all the plans and 73 percent of the network or IPA HMOs took into account qualitative information, such as professional reputation and patterns of care. When asked how much previous patterns of costs or utilization of resources influenced the selection of physicians, 61 percent of the respondents characterized the influence as small, 26 percent as moderate, and 13 percent as large.

Before signing a contract with a new physician, virtually all plans verified the physician's license and credentials, and almost all screened for reportable disciplinary actions, substance abuse, or similar problems. Sixty-six percent of the network or IPA HMOs visited the physician's office, reviewed whether the facility met set standards, and screened care by reviewing medical records. Only 7 percent of the PPOs took all these steps, and 32 percent took none of them.

Ninety-three percent of the plans had a formal process for recredentialing physicians, although 62 percent began to do this only in 1991 or later. Rates of physician turnover were low and were consistent with those in other recent studies.[16] Sixty-seven percent of the group or staff HMOs, 79 percent of the network or IPA HMOs, and 86 percent of the PPOs had an annual turnover rate (including both voluntary and involuntary departures) of 5 percent or less. The higher rate of turnover in the group or staff HMOs resulted from the turnover of newly hired physicians in their first two years of employment. The group or staff HMOs were more likely to have extensive orientation programs for new physicians than were the network or IPA HMOs or the PPOs.

Risk Sharing, Payment, and Financial Incentives

Risk sharing with physicians was usual in both types of HMO but rare in the PPOs (Table 3). Among the network or IPA HMOs, 84 percent had some sharing of risk with primary care physicians: 56 percent used capitation as a primary method of payment; and 28 percent used fee-for-service payments in some form along with withholding or bonuses. In contrast, only 20 percent of the network or IPA HMOs used capitation as a predominant method of payment for individual specialists; 54 percent had some form of risk sharing with specialists, 47 percent used capitated payment for certain specialties, and 33 percent used competitive bidding to obtain some specialty services. The specialties in which physicians were most commonly paid on a capitated basis were cardiology, mental health, radiology, orthopedics, and ophthalmology. The group or staff HMOs paid primary care physicians on a salary or capitated basis, but fewer than half did the same for specialists (data not shown). The PPOs primarily used fee-for-service payments.

Most of the HMOs adjusted payments to primary care physicians to create performance-based incentives. Fifty percent of the group or staff HMOs and 74 percent of the network or IPA HMOs adjusted payments according to utilization and cost patterns. More than half of the group or staff HMOs and the network or IPA HMOs adjusted payment on the basis of patients' complaints and measures of the quality of care. The group or staff HMOs were more likely than the network or IPA HMOs to reward productivity and ten-

...in the plan, whereas the net-...rk or IPA HMOs were more like-...to adjust payments according to ...results of consumer surveys.

...ractice and Utilization Management

The plans used several different ...financial methods to influence ...lical practice (Table 4). Ninety-... percent of the network or IPA ...MOs and 61 percent of the group ...staff HMOs required patients to ...ect a primary care physician, who ...s responsible for most referrals to ...cialists.

More than 95 percent of the ...MOs and 62 percent of the PPOs ...d a written quality-assurance plan, ...uality-assurance committee, and a ...tient-grievance system. Seventy-...ne percent of the group or staff ...MOs and 70 percent of the net-...rk or IPA HMOs required out-...me studies for particular clinical ...nditions, had targeted quality-...provement initiatives, and used ...come studies to identify needs for ...provement and to gauge success. ...dies of the treatment of asthma ...d diabetes and the use of mam-...graphy were the most common. ...ty-nine percent of the group or ...f HMOs and 80 percent of the ...work or IPA HMOs used physi-...n profiles and applied them. Sub-...ntially fewer PPOs than HMOs ...d outcome studies (31 percent) ...physician profiles (45 percent) in ...s way.

Practice guidelines were used less ...en than outcome studies or physician profiles. About ...ee quarters of the HMOs and 28 percent of the ...POs used formal, written practice guidelines. These ...st commonly applied to childhood immunizations, ...management of asthma, mammographic screening, ...d screening for colorectal cancer. Almost all plans ...d procedures for utilization review. In most plans, ...tient-level claims or encounter data on physicians' ...rvices and other ambulatory care services were col-...ted even when providers were paid on a capitated or ...laried basis. But physicians submitted more than 90 ...rcent of encounter forms (dummy claims) in only a ...nority of plans. Such information is less likely to be ...ilable in the network or IPA HMOs than in the ...oup or staff HMOs.

Similarities among HMO Plans

There were many similarities in structure between ...group or staff HMOs and the network or IPA ...MOs. Fifty-five percent of the plans identified as group or staff HMOs were actually mixed models, with traditional HMO coverage provided by a network or IPA. Only 59 percent of the group or staff HMOs used physicians in large multispecialty groups to provide care to more than two thirds of their enrollees. Moreover, only 44 percent reported that their members made up 80 percent or more of the practice of a typical physician in their plan, whereas 45 percent of the network or IPA HMOs reported that their members accounted for at least 20 percent of a typical physician's practice.

Table 3. Procedures Used by Managed-Care Plans to Pay Physicians.

Procedure	All Plans (N = 108)	Group or Staff HMOs (N = 29)	Network or IPA HMOs (N = 50)	PPOs (N = 29)
		percent		
Primary care physicians				
Predominant payment for sole or largest benefit plan involves:				
Some sharing of risk with providers*	60	68	84	10†‡
Capitation as predominant method	37	34	56§	7†‡
Salary with no withholding or bonus	8	28	2‡	0‡
Fee for service with no withholding or bonus	31	3	12	90†‡
Basis of payment adjustment¶				
Utilization or cost measures	57	50	74§	34†
Patient complaints or grievance	49	57	61	21†‡
Quality measures	46	54	64	7†‡
Consumer surveys	36	37	55	3†‡
Provider productivity	24	43	26	3†‡
Enrollee turnover rate	21	11	36§	3†
None of above	28	29	14	55†§
Financial reward given for devoting a higher percentage of time to plan, increasing number of patients, longevity, exclusivity, or willingness to provide a wider range of services‖	52	69	64	14†‡
Specialty physicians				
Predominant payment for sole or largest benefit plan involves:				
Some sharing of risk with providers* **	43	59	54	3†‡
Capitation as predominant method	18	31	20	0†‡
Salary with no withholding or bonus	6	17	2§	0§
Fee for service with no withholding or bonus	52	24	42	97†‡
Capitation for individual specialties, pooled capitation across specialties, risk sharing based on withholding or bonuses, or competitive bidding				
Any of above	69	97	86	10†‡
Capitation for individual specialties	42	69	47	7†‡
Competitive bidding	28	31	33	17

*Physicians are paid some form of capitation (with or without other withholding or bonuses), or withholding or bonuses are applied to salary or fee-for-service arrangements. Withholding is similar to a bonus, except that funds are initially withheld and then returned in part or in whole at the end of the payment period.

†$P<0.01$ for the comparison with network or IPA HMOs.

‡$P<0.01$ for the comparison with group or staff HMOs.

§$P<0.10$ for the comparison with group or staff HMOs.

¶The number of plans responding to this item ranged from 104 to 106 (27 to 29 group or staff HMOs, 48 or 49 network or IPA HMOs, and 29 PPOs).

‖This question did not refer specifically to primary care physicians, but these approaches are most relevant to them.

**Only 107 plans responded (29 group or staff HMOs, 49 network or IPA HMOs, and 29 PPOs).

Discussion

Our findings indicate that managed-care plans have complex systems for recruiting physicians, paying them, and monitoring their performance. Such systems are much more likely to be found in HMOs than in PPOs, perhaps because purchasers have recently encouraged the accreditation of such plans by the National Committee for Quality Assurance.[17]

Our study is descriptive, and the data come from un-

Table 4. Procedures Used by Managed-Care Plans to Monitor Practice and Utilization.

PROCEDURE	ALL PLANS (N = 108)	GROUP OR STAFF HMOs (N = 29)	NETWORK OR IPA HMOs (N = 50)	PPO N =
		percent		
Clinical structure (traditional HMO benefit plans)				
Plan generally holds primary care physicians responsible for referral to most specialists	94	96	92	—*
Patients are required to select an individual primary care physician†	82	61	92‡	—*
Medical management				
(1) Quality structure				
Plan has a quality-assurance document, quality-assurance committees, and active patient-grievance procedures	87	97	96	62‡
(2) Quality monitoring and focused studies				
Plan requires clinically focused or outcome studies for specific clinical conditions and targeted quality-improvement initiatives, and uses them to identify needed improvements and to gauge success¶				
All of the above	62	79	70	31‡
Focused studies conducted regularly	83	100	96	45‡
(3) Profiling				
Plan uses profiling, provides physician feedback, and identifies areas for system-wide improvement‖				
All of the above	68	69	80	45§*
Any use of profiles	74	76	86	52§*
(4) Practice guidelines				
Plan uses established, formal, written practice guidelines, does so fairly extensively (in more than a few areas), monitors compliance, and meets with physicians to review results††				
All of the above	26	31	34	7§*
Any use of guidelines	63	76	76	28‡§
(5) Utilization review				
Preadmission review for all nonemergency admissions, concurrent and retrospective review, discharge planning (that does not rely on hospital staff), and ambulatory review for resource-intensive services‡‡				
At least four of five	62	72	70	37‡§
Any of the above	95	97	100	86§
(6) Data				
Plan maintains patient-level claims or encounter data base for hospital stays	91	90	100**	76§
Plan has patient-level claims or encounter data base for in-plan physician and other services, requires dummy claims or encounter forms, and estimates that ≥90% of encounter forms are submitted				
Requires data base	88	93	94	72§**
Requires data base with dummy claims§§	74	82	69	—*
Requires data base with dummy claims§§ and ≥90% of encounter forms submitted	24	39	13**	—*

*Only applicable to six PPOs with traditional HMO benefits.

†Only 107 plans responded (28 group or staff HMOs, 50 network or IPA HMOs, and 29 PPOs).

‡$P<0.01$ for the comparison with group or staff HMOs.

§$P<0.01$ for the comparison with network or IPA HMOs.

¶Clinically focused studies were defined as studies of performance of patient outcomes in areas such as childhood immunization, pregnancy, diabetes, breast cancer or mammography, lead toxicity, and sickle cell disease. One of the items specified that these must be done on a regular basis.

‖Profiling was defined as examining patterns of practice through various use or outcome rates aggregated over time for a defined population of patients and comparing them with other practice patterns.

**$P<0.10$ for the comparison with group or staff HMOs.

††Practice guidelines were defined as an explicit statement of what is known and believed about the benefits, risks, and costs of particular courses of medical action to assist decisions about appropriate health care for specific clinical conditions.

‡‡Respondents were asked to characterize their process for preadmission review in various ways. Those not counted as "yes" include, for example, those in which no specific action is needed, although the pattern may be monitored, those in which an intermediate entity or patient is responsible for preadmission review, and those covering only some nonemergency admissions.

§§If applicable (excludes those using fee for service as the predominant way of paying primary care and specialty physicians in the sole or largest benefit plan).

audited reports from the plans themselves. Thus, it can offer little insight into how the arrangements between physicians and managed-care plans influence the accessibility, cost, or quality of care.

Our findings do suggest, however, that many of the differences between specific HMOs cannot be explained by their classification as group or staff HMOs or as network or IPA HMOs. The Congressional Budget Office's estimates assume that most cost savings attributable to HMOs result from group or staff plans, not from network or IPA plans, on the basis of the belief that most network or IPA HMOs do not create the conditions on which savings depend[10,11]: "These conditions include [the presence of] cost conscious providers, an effective network for information and control, [placing] providers at financial risk, and [generating] a substantial portion of each provider's patient load."[10] We found that many large network or IPA HMOs met at least some of these conditions and that the two types of HMO did not differ from one another as much as is often assumed. Diversity in managed care occurs within as well as across types of plans.

Common arrangements between managed-care plans and physicians appear to result in less independence and less control over income and practice for physicians. Nonetheless, the emphasis on outcome studies

and enrollee-based clinical information may have beneficial effects for plan members, because this approach accounts for those who do not use services as well as those who do.

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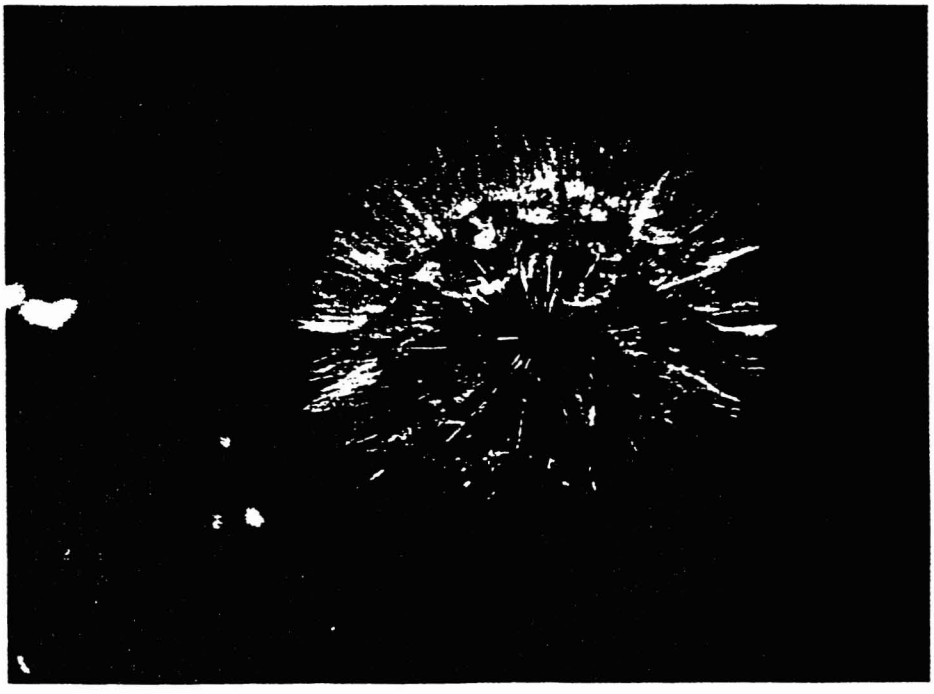

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