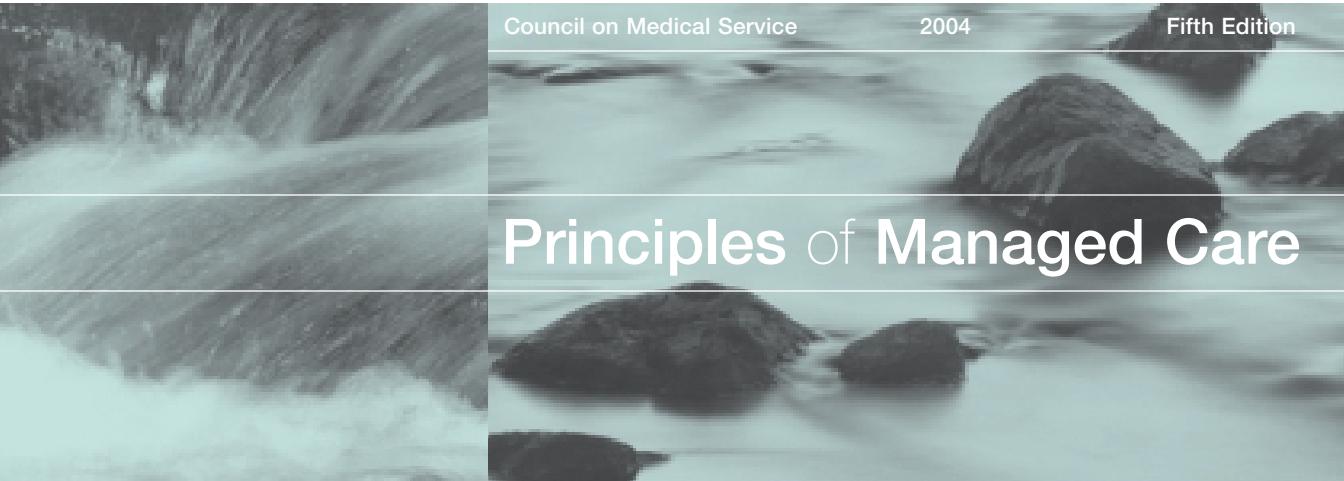


American Medical Association

Physicians dedicated to the health of America

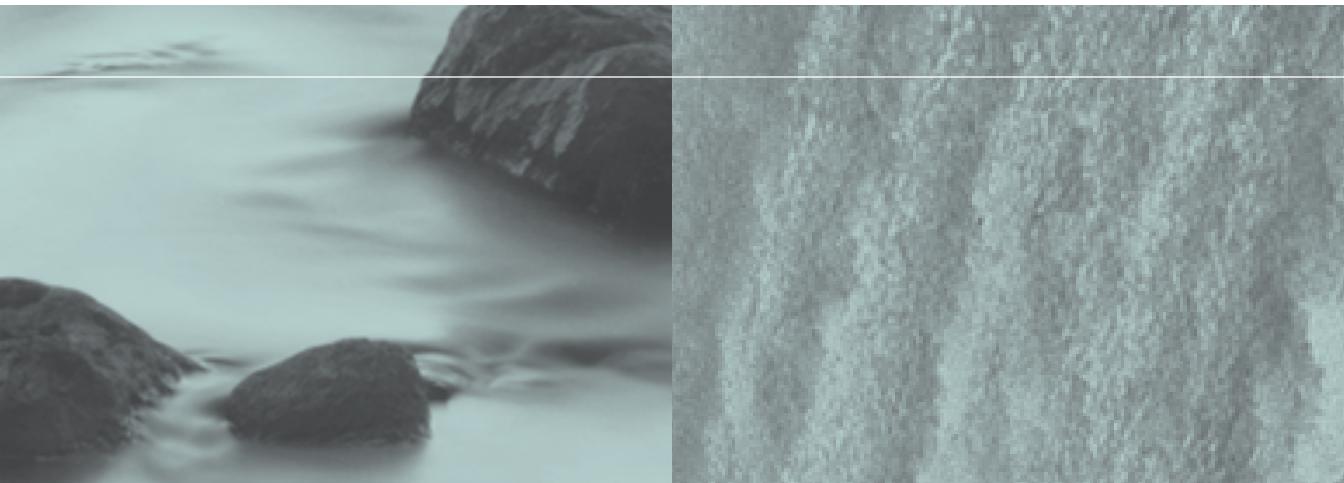


Council on Medical Service

2004

Fifth Edition

Principles of Managed Care



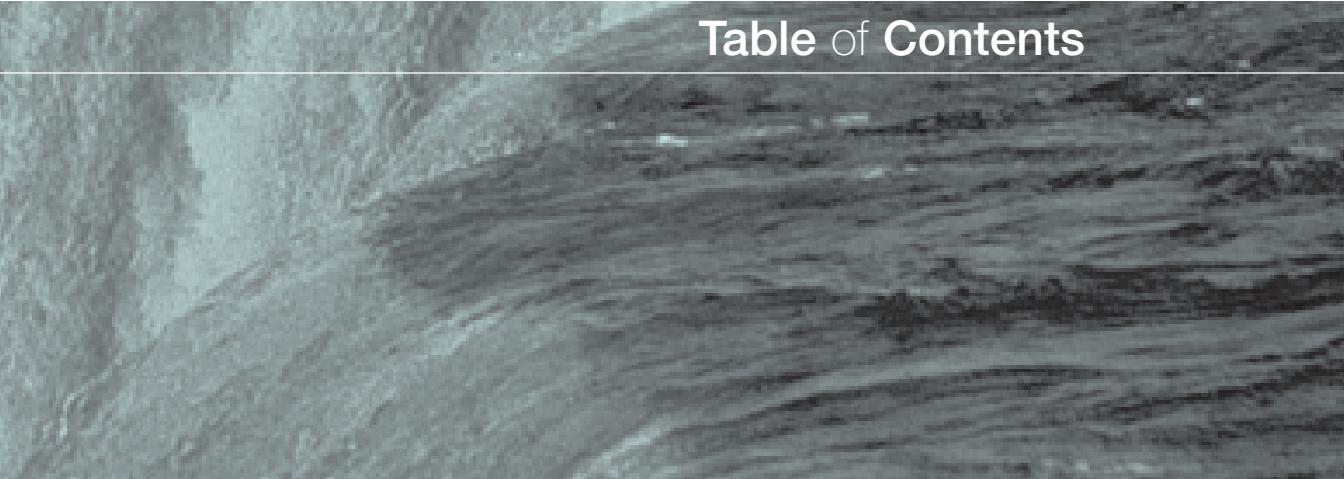
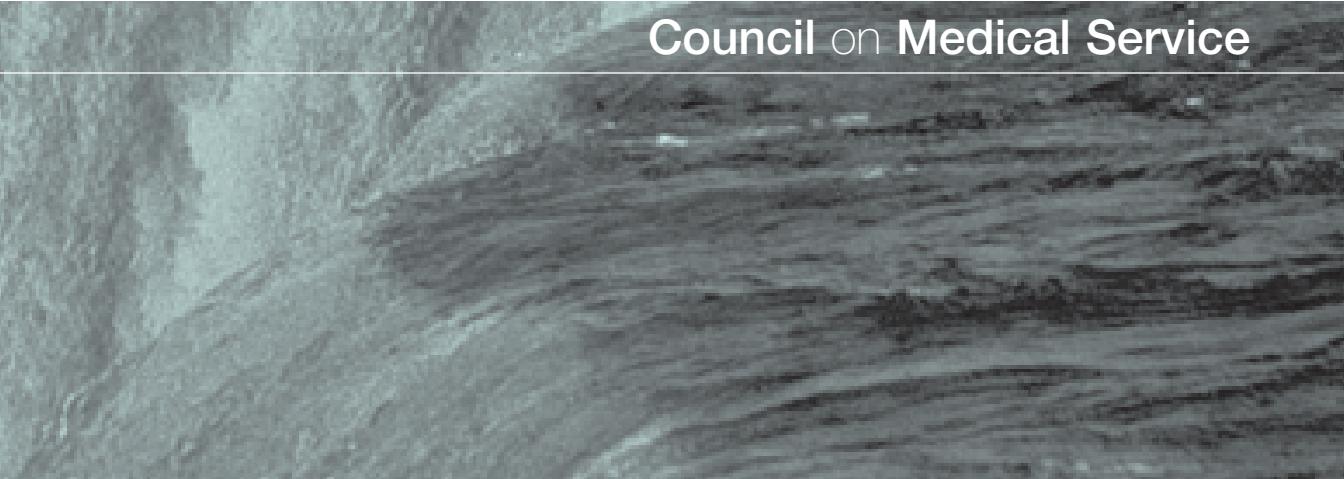


Table of Contents

2	Preface
3	Disclosure Provisions
4	Selective Contracting
5	Credentialing and Recredentialing
6	Financial Incentives
7	Managed Care Contracts
10	Physician Decision-Making
13	Case Management
14	Claims Submission
16	Utilization Management and Medical Necessity
18	Independent and External Review
19	Telephone Triage and Counseling
21	Disease Management
23	Medical Care “Carve-Outs”
25	Hospitalist Programs
26	Medical Director Qualifications
27	Medicare and Medicaid Managed Care
30	References



Council on Medical Service

The AMA's Council on Medical Service is charged with studying and evaluating the social and economic aspects of medical care and the practice of medicine; and, on behalf of the public and the profession, suggesting means for the timely development of services in a changing socioeconomic environment.

Many of the policies that appear in this document were recommended by the Council on Medical Service.

The American Medical Association (AMA) defines “managed care” as processes or techniques used by any entity that delivers, administers and/or assumes risk for health services in order to control or influence the quality, accessibility, utilization, costs and prices, or outcomes of such services provided to a defined population. Managed care techniques currently include any or all of the following:

- prior, concurrent, and retrospective review of the quality, medical necessity, and/or appropriateness of services or site of services;
- controlled access to and/or coordination of services through case management, disease management and demand management, which all require increased access to patient medical records and therefore raise confidentiality and privacy concerns;
- efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions;
- provision of services through a network of contracting clinicians and facilities, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria;
- enrollee financial incentives and disincentives to use particular clinicians or specific facilities; and
- acceptance by participating clinicians and facilities of financial risk, or discounted fees, for some or all of contractually obligated services.

The use of managed care among employers, third party payers, and state and federal programs has steadily risen during recent decades. As a result, managed care has strongly influenced the practice of medicine and has exerted immense pressure on physicians.

The AMA has continued to develop a strong policy base and has established various mechanisms to address issues related to managed care. The following Principles of Managed Care represents a key component in these efforts. It is hoped that these principles, which are based entirely on AMA policy, will promote effective managed care techniques that are fair and equitable to physicians in ensuring that high quality health care services are delivered to patients.

Managed care organizations and payer groups are strongly encouraged to use these guidelines in developing their own policies and procedures. In addition, any public or private entities that evaluate managed care organizations or their contracted entities for purposes of certification or accreditation are encouraged to use these principles in conducting their evaluations.

All managed care plans should be required to clearly and understandably communicate to enrollees and prospective enrollees, in a standard disclosure format, those services which they will and will not cover and the extent of that coverage. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements, or other restrictions that may limit services, referral, or treatment options. (H-285.998 [5])

Physicians must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (H-285.982 [f])

Physicians must assure disclosure of any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients, or that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients overall access to care. Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. (H-140.978 [4,5])

Managed care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed should report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to their patients. (H-285.984 [3])

It is the responsibility of the patient and his or her managed care plan to inform the treating physician of any coverage restrictions imposed by the plan. (H-285.998 [5])

Selective Contracting

4

Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (H-285.991 [1,a])

Managed care organizations should disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed. (H-285.984 [2])

Physicians should have the right to apply to any managed care plan or network in which they desire to participate. (H-285.991 [1,b]) Physician applications should be approved if they meet physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence, and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive relationship to the quality and appropriateness of care and to professional competency. (H-230.975 [1])

Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (H-285.991 [1,c])

Managed care plans that contract with selected providers should have an established appeals mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan. (H-285.997 [2])

Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason, the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (H-285.991 [1,d])

Credentialing and Recredentialing

Managed care companies should be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept. (H-285.948)

Managed care organizations, and insurance companies are encouraged to use state and county central credentialing services, where available, for purposes of credentialing plan physician applicants. (H-285.979 [4])

Hospital medical staff privileges should not be required for physician participation in managed care contract panels, and managed care entities should have an effective, physician directed peer review mechanism to fairly evaluate their participating physicians. (H-285.953)

Final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed. (H-180.956 [1])

Health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification. (H-180.956 [2])

Managed care organizations should recredential participating physicians no more frequently than every two years. (H-285.979 [3])

Recredentialing of a physician or physician group by a managed care plan should not be triggered by a change of practice location within the plan's contractually defined service area, by a change in practice by a currently credentialed physician to a different group that is also currently credentialed, or to solo practice, or by a change in staff size of the physician group. Any significant resulting change in the number, type, quality or costs of services provided in the practice should be addressed first through physician-directed quality assurance and utilization management mechanisms established in the plan. (H-285.934 [1])

Recredentialing or reconsideration of plan participation for a physician or physician group may legitimately be precipitated by a relocation of the practice outside of the plan's service area. (H-285.934 [3])

Recredentialing of a physician or physician group by a managed care plan should not be required when two or more such plans merge. (H-285.934 [2])

Financial Incentives

6

The first duty of physicians must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice. (H-140.941 and E-8.045)

Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (H-285.951 [4])

Clinics, laboratories, hospitals, or other health care facilities that compensate physicians for referral of patients are engaged in fee splitting which is unethical. (E-6.03)

Patients are entitled to all the benefits outlined in their insurance plan. Therefore, it is unethical for a referring physician to restrict the referral options of patients who have chosen a plan that provides for access to an unlimited or broad selection of specialist physicians. It is also unethical to base the referral of these patients on a discount for the capitated patients in a primary care physician's practice. (E-8.052)

Financial incentives should enhance the provision of high quality, cost-effective medical care. (H-285.951 [3])

Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (H-285.951 [8])

Appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (H-285.951 [9])

Incentives should be designed to promote efficient practice, but should not be designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, incentives should also be based upon measures of quality of care and patient satisfaction. (E-8.054)

Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (H-285.951 [7])

At a minimum, the information disclosed in managed care contracts should be in clear terms and include the following (H-285.946):

- reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
- any proprietary “correct coding” CPT bundling program that are used;
- grievance and appeal mechanisms;
- conditions under which a contract can be terminated by a physician or health plan;
- patient confidentiality protections;
- policies on patient referrals and physician use of consultants; and
- a current listing by name of the physicians (by specialty) and ancillary service providers participating in the plan.

Participating physicians should be allowed a minimum of 60 days to review amendments to managed care contracts. (H-285.952)

When a “sale of covered lives” takes place due to the sale or merging of health plans, the health plan emerging from such transactions should be required to abide by the original health plan contract with the patient, especially

those contract provisions that address health benefits coverage and access to physicians. (H-285.935)

Third party payer contracts should exclude any provisions that prohibit physicians from discussing any issue with patients or other health professionals that may have a bearing on patient health, including the consequences of payment decisions by a third party payer. (H-285.963 [2])

Physicians should consider obtaining their own financial advisors when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments. (H-285.951 [12])

Physicians should consult with legal counsel prior to agreeing to any health plan contract that contains financial incentives, to assure that such incentives will not inappropriately influence their clinical judgment. (H-285.951 [10])

Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (H-285.951 [10])

Managed Care Contracts

Continued

8

Physicians should avoid contracts containing “termination without cause” provisions that do not contain due process protections and appeal processes to an independent panel. (H-285.942)

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but they should be aware of the potential for some types of systems to create conflicts of interest, due to the use of financial incentives in the management of medical care. (H-285.951 [2])

Physicians should carefully review their managed care contracts to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness. (H-320.953 [5])

Managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner should be opposed. (H-285.940)

All managed care contracts should expressly require the managed care plan to provide meaningful due process protections, in order to prevent wrongful and arbitrary contract terminations that leave the physician without means of redress. (H-285.996)

Covenants not to compete restrict competition, disrupt continuity of care and potentially deprive the public of medical services. Physicians should not agree to any restriction on their right to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients’ choice of physician. (H-140.942)

Contracts that tie a physician’s membership in a managed care panel (eg, a PPO) to that physician’s participation in any other managed care panel (eg, an HMO) should be opposed. (H-285.989)

Contracts containing “most favored nation” clauses that require physicians to give a third party payer his or her most discounted rate for medical services should be opposed. (H-385.938)

Hold harmless clauses in managed care contracts that effectively shift plan liability to the physician should be explicitly identified as such and should be opposed. (H-285.955) and (H-285.995 [1])

Physicians should consider consulting with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. (H-285.995 [1])

Managed care contract provisions that prohibit physician payment for the provision of administrative services should be opposed. (H-285.943 [1])

Physicians entering into capitated arrangements with managed care plans should seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services and physicians entering into fee-for-service arrangements with managed care plans should seek a separate case management fee or higher level of payment to account for the provision of administrative services. (H-285.943 [2])

The practice of “retroactive or late assignment” of patients by managed care entities should be eliminated. This practice involves the failure of managed care organizations to require enrollees in a capitated plan to select a physician at the time of enrollment, inform the physician of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and pay the responsible physician the capitated rate until after the patient has sought care. (H-285.947 [1])

The medical services agreements between physicians and preferred provider organizations (PPOs) should adhere to the following principles (H-415.987 [1]):

- Discounts shall be extended only to enrollees of PPOs who have cards identifying them as such.
- All PPO members eligible for discounts shall be subject to mechanisms that will direct patients to the physician’s practice.
- The types of entities that can be added to the network shall be identified in advance, and providers shall receive timely notice when payers or employers are added.
- All members added to the PPO shall be subject to the same mechanisms to direct patients to the physician’s practice.
- Any discounts applicable to a PPO enrollee shall be disclosed at the time coverage is verified.
- The sale or other unauthorized use of contract rate information shall be specifically prohibited.

Certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan, whether in primary care or another specialty, either unilaterally or with consultation from the plan, including but not limited to the following (H-285.954 [1]):

- what diagnostic tests are appropriate;
- when and to whom in-plan physician referral is indicated;
- when and to whom out-of-plan physician referral is indicated;
- when and with whom consultation is indicated;
- when non-emergency hospitalization is indicated;
- when hospitalization from the emergency department is indicated;
- choice of in-plan service sites for specific services (office, outpatient department, home care, etc.);
- hospital length of stay;
- frequency/length of office/outpatient visits or care;
- use of out-of formulary medications;
- when and what surgery is indicated;
- when termination of extraordinary/heroic care is indicated;
- recommendations to patients for other treatment options, including non-covered care;
- scheduling on-call coverage;
- terminating a patient-physician relationship;
- whether to work with, and what responsibilities should be delegated to, a mid-level practitioner; and
- determination of the most appropriate treatment methodology.

All managed care plans and medical delivery systems must include significant physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals that should extend to all sites of care. The principles of self-governance for managed care medical staffs should include, but not be limited to:

- the development of medical staff bylaws which cannot be unilaterally changed by the governing board of the medical delivery system; (H-285.983 [2])
- due process protections for physicians credentialed by the medical delivery system; (H-285.983 [2] and H-285.931 [1])
- representatives of the practicing physicians in a health plan must be the decision-makers in the credentialing and recredentialing process; (H-285.931 [2])

- full indemnification by the managed care entity of physicians who, in good faith, serve as members of credentialing, quality assurance, and utilization review committees of the medical delivery system; (H-285.983 [2])
- practicing physician involvement in: (a) the selection and removal of their leaders who are involved in governance, (b) the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; and (c) the development of criteria used by the health plan in determining medical necessity and coverage decisions; (H-285.931 [1,b])
- peer accountability for professional decisions based on accepted standards of care and evidence-based medicine; (H-285.931 [1,c])
- involvement of all specialties participating in clinical processes toward the development of clinical practice guidelines, disease management protocols; (H-285.931 [3])
- appropriate, periodic, and comparative utilization data for all practicing physicians; and (H-285.931 [7])

- the availability of skilled resource people and information management systems to practicing physicians involved in continuous quality improvement activities so that they have access to information on clinical performance, patient satisfaction, and health status. (H-285.931 [8])

The development and use of Level of Care Guidelines is supported when certain criteria are met. Level of Care Guidelines should:

- function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions; (H-285.920 [1,a])
- acknowledge the complexity of care for each patient under the particular set of clinical circumstances; (H-285.920 [1,b])
- apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment; (H-285.920 [1,c])
- be developed under the direction of actively practicing physicians; (H-285.920 [1,d])
- be developed based on individual patient severity of illness and intensity of service; (H-285.920 [1,e])

Physician Decision-Making

Continued

12



- be validated through standard data quality control checks and professional advisory consensus; (H-285.920 [1,f])
- be reviewed and updated; and (H-285.920 [1,g])
- allow for a timely appeal process. (H-285.920 [1,h])

Private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (H-285.920 [2])

Physicians participating in managed care plans must be able to comment on and present their positions regarding the managed care plan policies and procedures without threat of punitive action. (H-165.909 [2])

Physician representatives and leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan and participating physicians must have an identified process to access their physician representatives. (H-285.931 [9])

With the present specialization of medical services, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient; the physician is best suited by professional preparation to assume this leadership role. (H-285.998 [4])

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. (H-285.998 [4])

Appropriate payment for physician time and efforts in providing case management and supervisory services is warranted for services that include, but are not limited to, coordination of care, telephone consultations, and office staff time spent to complying with third party payer protocols. (H-385.951 and H-390.878)

Any managed care plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations. (H-285.998 [4])

Where case management or coordination might limit access to appropriate medical care, patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount. (H-200.969 [4])

Managed care plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. (H-285.998 [4])

Managed care plans should provide enrollees, on an ongoing basis, with the right to select a new primary physician from the panel of physicians, and to appeal to the plan when the patient is dissatisfied with his or her present primary physician. (H-165.908 [2])

Health plans that restrict a patient's choice of physicians or hospitals or surgical pathology and cytopathology services should offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional and affordable "point-of-service" type feature so that patients who choose such plans may elect to self refer to physicians outside of the plan at additional cost to themselves. (H-165.908 [1])

Any point-of-service options under health system reform should have out-of-plan cost-sharing levels that are nonpunitive, actuarially determined, and affordable. (H-165.903)

To encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing, public and private payors who do not currently do so should cover the processing cost of physician electronic claims and remittance advice.

(H-190.978 [1,a])

Vendors, claims clearinghouses, and payors should offer physicians a full complement of EDI transactions (eg, claims submission; remittance advice; and eligibility, coverage and benefit inquiry). (H-190.978 [1,b])

Vendors, clearinghouses, and payors should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim. (H-190.978 [1,c])

All clearinghouses should act as all-payor clearinghouses (ie, accept claims intended for all public and private payors). (H-190.978 [1,d])

Practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products.

(H-190.978 [1,e])

Insurance companies should adopt a standardized or open electronic claims submission protocol such as the National Standard Format (NSF) or American National Standard Institute (ANSI) such as utilized by Medicare, thus allowing physicians and other providers of health care to utilize Electronic Data Interchange (EDI) efficiently and economically without needed redundant and proprietary standards and software for electronic claims submission.

(H-190.976)

Practitioners should have free choice, without penalty, to transmit claims data either by paper claim or electronically. (H-330.954)

All health insurance and managed care companies should pay for clean claims submitted electronically within fourteen days and for paper claims submitted within 30 days, with interest accruing thereafter. (H-190.959 [1] and H-190.981)

Receipt of each electronic claim should be acknowledged within 24 hours. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. (H-190.964 and H-190.959 [2])

Insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner. (H-190.965)

Heavy penalties should be imposed on health insurance and managed care companies, including their employees, that do not comply with the laws and regulations establishing guidelines for claims payment. (H-190.959 [3])

State and federal agencies are urged to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced. (H-190.969 [1])

Private sector health care accreditation organizations are urged to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (H-190.969 [7])

Utilization Management and Medical Necessity

Medical necessity is defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider. (H-320.953 [3])

Determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided. (H-320.953 [7])

The medical protocols and review criteria used by managed care plans in any utilization review or management program must be developed by physicians. (H-285.998 [5])

Managed care plans should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms used in the review process, as well as how they were developed. (H-285.998 [5] and H-320.968 [2,a])

Any managed care plan utilizing a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. (H-285.998 [5] and H-320.968 [2,e])

The practice of unilateral, arbitrary recoding and/or bundling by all payers should be vigorously opposed. (H-70.937 [1])

When a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes:

- the principal reason(s) for the determination (H-320.948 [1]);
- the clinical rationale used in making the determination; and (H-320.948 [2]);
- a statement describing the process for appeal. (H-320-948 [3])

A physician of the same specialty must be involved in any decision by a utilization review or management program to deny or reduce coverage for services based on questions of medical necessity. (H-285.998 [5], H-165.951 [3,e,4] and H-320.968 [2,b])

Any physician who makes judgments or recommendations regarding the necessity, appropriateness, or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service, and should be professionally and individually accountable for his or her decisions. (H-285.998 [5], H-165.951 [3,4,e] and H-320.968 [2,d])

It is the responsibility of the utilization review program or managed care plan to credential or certify that its reviewers are appropriately licensed and have the required experience to perform review. (H-320.969 [4])

A physician whose services are being reviewed for medical necessity should be provided the identity and credentials of the reviewing physician on request. (H-285.998 [5])

Any managed care plan that compiles information on physician performance should share that information with the practitioners involved prior to public release. (H-285.994 [3])

Any health plan using managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Health plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions, review requirements, financial arrangements, or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. (H-285.998 [5] and H-320.968 [3])

Federal law should be enacted to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care. (H-285.945)

Independent and External Review

Every organization that reviews or contracts for review of the medical necessity of services should establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review. (H-320.968 [2,c])

All managed care organizations should contain an external review procedure with the following basic components (H-320.952):

- It should apply to all health carriers.
- Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician.
- Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational.
- Internal grievance procedures should generally be exhausted before requesting external review.
- An expedited review mechanism should be created for urgent medical conditions.
- Independent reviewers practicing in the same state should be used whenever possible.
- Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review.
- The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information.
- External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues, the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

Telephone counseling services must appoint a physician director. Such services are not absolved of that responsibility by a disclaimer to the callers. A physician director must be ultimately responsible for the telephone triaging of patients in a given system. (H-160.935 [1])

A physician director of telephone counseling services must be responsible for (H-160-935 [a-e]):

- providing and updating protocols and algorithms for phone counseling by non-physicians;
- identifying high-risk patients who must be directly and immediately referred to physicians at all times;
- supervision and review of second-level triage provided by advanced nurse practitioners and physician assistants;
- ensuring permanent records of all calls received; and
- maintaining accountability for the patient until a referral has been effected with an accepting physician.

Telephone triage centers should routinely inform primary or principal care physicians of the disposition of all calls received from their patients. (H-285.944 [14])

Telephone counseling and triage should be performed by health professionals with a level of knowledge and training no less than that of a registered nurse. (H-285.944 [15])

Qualified physicians should be readily accessible for consultation and second-level triage to the nurses or other health professionals providing telephone counseling or triage. (H-285.944 [16])

The referral algorithms or protocols used in telephone triage should be developed by physicians knowledgeable in dealing with the conditions addressed, and should be updated regularly. (H-285.944 [12])

Telephone counseling and triage centers should routinely compile outcome information on all calls handled, and should modify their operating policies and referral protocols as needed to enhance the effectiveness of the service. (H-285.944 [12])

Telephone Triage and Counseling

Continued

20

Organizations that provide telephone triage services should provide such services 24 hours a day on a year-round basis and calls should be handled as expeditiously as possible. (H-285.944 [19])

Physicians performing second level triage for telephone triage centers should be compensated for such services by the center or sponsoring health plan. (H-285.944 [17])

Compensation for individuals performing telephone counseling and triage should not be based on the number or the disposition of calls handled. (H-285.944 [18])

Payment for emergency or other covered services by a health plan should not be conditioned on prior use of the plan's telephone triage center by an enrollee seeking such services, or on adherence by the enrollee to triage center recommendations. Enrollees eligible to use or accessing the triage center should be informed of this policy, and of their right to have immediate access to a physician if desired. (H-285.944 [12])

The primary goals of disease management should be as follows:

- To improve outcomes by the provision of timely and appropriate preventive, therapeutic and restorative services. Cost savings and care efficiencies resulting from such services are a secondary but legitimate objective. (H-285.944 [1,a])
- To promote cooperation between primary care and specialty care physicians to provide a continuum of care for specific health care needs. (H-285.944 [1,b])

Disease management should continue to place major emphasis on educating and empowering patients to more successfully manage their own health and intelligently use care resources. (H-285.944 [2])

Managed care organizations that provide disease management should involve the patient's current primary or principal care physician in the disease management process as much as possible, and minimize arrangements that may impair the continuity of a patient's care across different settings. (H-285.944)

The clinical practice guidelines utilized in disease management should be developed by physicians knowledgeable in dealing with the conditions addressed, and should be updated regularly. (H.285.944 [3])

The decision to participate or not participate in a disease management program should always be the prerogative of the patient, who should be fully informed of any plan coverage conditions attendant on such decisions. (H-285.944 [4])

Physicians should be able to deviate from disease management practice guidelines without incurring sanctions or jeopardizing coverage for services, when in their judgment such deviation is indicated by the medical needs or desires of individual patients. (H-285.944 [5])

Attention to the performance of physicians in disease management programs should be triggered by concern with a physician's overall practice patterns rather than by deviation from practice guidelines in a single case. Emphasis in remedial activities should be on helping the practitioner to correct any overall performance problems identified by peer review, rather than on sanctions. (H-285.944 [6])

Non-physicians who function as care coordinators in disease management programs should be certified or licensed as physician assistants or nurse practitioners, or have at least a comparable level of training. (H-285.944 [7])

Disease Management

Continued

22

The overall authority for decisions to use or not use specialized care and ancillary or supportive services or products for patients enrolled in a disease management program should rest with the primary or principal care physician providing care in the program. (H-285.944 [8]).

The primary or principal care physician in a disease management program should strive to assure effective collaboration among the different programs and personnel needed for care of patients with comorbidities, and should be routinely informed by such personnel of the services they provide. (H-285.944 [9])

Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient's permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient's treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient's health care needs in optimal fashion. (H-285.921)

Physicians who provide care in disease management programs should be fully licensed to practice medicine in the jurisdiction of the program's location, and should be professionally and legally accountable for any adverse patient events resulting from that care. (H-285.944 [10])

In disease management programs conducted by drug manufacturers, the choice of pharmaceuticals used in program formularies and for care of individual patients should not be restricted to those of the sponsoring manufacturer, but should be based on the clinical judgment of participating physicians and validated outcome studies. (H-285.944 [11])

Medical Care “Carve-Outs”

The term “carve-out” be defined as follows:

A financial arrangement for the provision and/or management of a clinically defined subset of a health plan’s benefits, which is separate from the financial arrangement for the provision and/or management of most or all of the plans’ other health benefits. (H-285.919)

Carve-outs should be opposed when used as a tool to deny necessary and appropriate care, reduce the likelihood that care will be sought, to intimidate patients or referring physicians from initiating needed referrals, or to create additional burdens to either patients or physicians. (H.285.922)

In order to protect the large number of patients currently covered by carve-out arrangements, all managed care plans that provide or arrange for behavioral health care should adhere to the following principles, and any public or private entities that evaluate such plans for the purposes of certification or accreditation should utilize these principles in conducting their evaluations:

- Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice. (H-285.956 [1])
- Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees. (H-285.956 [2])
- Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician. (H-285.956 [3])

Medical Care

“Carve-Outs”

Continued

24

- Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists for the appropriate diagnosis, evaluation, and treatment of patients with medical and psychiatric comorbidities. (H-285.956 [4] and (H-285.925 [1])
- Plans should encourage a disease management approach to care of behavioral health problems. (H-285.956 [5])
- Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements. (H-285.956 [6])
- Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient’s privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care. (H-285.956 [7])
- Plans assuming risk for behavioral health care should consider “soft” capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment. (H-285.956 [8])
- Where a cap on the number of mental health visits is imposed by a health plan, re-certification for additional visits should be granted upon request by the treating psychiatrist, or other health care professional, without additional personal information from the patient. (H.285.925 [2])
- Plans should conduct ongoing assessment of patient outcomes and satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback. (H-285.956 [9])

Managed care enrollees and prospective enrollees should receive prior notification regarding the implementation and use of “admitting officer” or “hospitalist” programs. (H-285.964 [1])

Participation in “admitting officer” or “hospitalist programs” developed and implemented by managed care organizations should be at the voluntary discretion of the patient and the patient’s physician. (H-285.964 [2]) and (H-285.960)

No punitive measure should be imposed on physicians or patients who decline participation in “hospitalists programs.” (H-285.964 [4])

Hospitalist systems when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained. (H-285.964 [3])

Any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants should be opposed. (H-285.964 [5])

Medical Director Qualifications

To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall adhere to the following “Guidelines for Qualifications of Medical Directors of Managed Care Organizations” (H-285-987):

- hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that medical director will be making clinical decisions or be involved in peer review that medical director should have a current license in each applicable state;
- meet credentialing requirements equivalent to those met by plan providers;
- be familiar with local medical practices and standards in the plan’s service area;
- be knowledgeable concerning the applicable accreditation or “program approval” standards for preferred provider organizations and health maintenance organizations;
- possess good interpersonal and communications skills;
- demonstrate knowledge of risk management standards;
- be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
- demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
- be able to establish fair and effective grievance resolution mechanisms for enrollees;
- be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and
- be willing to interact with physicians on denied authorizations.

Utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. Federal and state patient protection legislation should subject medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions. (H-285.939)

In keeping with its support for free market competition among all modes of health care delivery and financing, the AMA strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. (H-290.984)

Medicare Advantage organizations should be required to adhere to the following guarantees to assure quality patient care to medical beneficiaries:

- A Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty. (H-330.916 [1])
- If a Medicare Advantage plan is decertified, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished. (H-330.916 [2])
- Any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an independent review body. (H-330.916 [3])

- Medicare HMOs should have large enough physician panels to assure that a large influx of beneficiaries will not result in quality or access problems. (H-330.915 [2])

Medicare managed care plans (eg, Medicare HMOs, Medicare Choice plans, etc.) that use the RBRVS should do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program. (H-330.928)

Geographic variations in capitation rates from Medicare or Medicaid should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. (H-400.955 [1])

The AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. (H-290.985)

Medicare and Medicaid Managed Care

Continued

28

The following criteria should be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and by physician organizations monitoring the implementation of managed care for Medicaid beneficiaries (H-290.985):

- adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment;
- phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers;
- geographic dispersion and accessibility of participating physicians and other clinicians;
- education of beneficiaries regarding appropriate use of services, including the emergency department;
- availability of off-hours, walk-in primary care;
- coverage for clinically effective preventive services;
- responsiveness to cultural, language and transportation barriers to access;
- in programs where more than one plan is available, beneficiary freedom to choose his or her plan, enforcement of standards for marketing and enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers;
- beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied;
- significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs;
- ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program;
- adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers;
- intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services;

- treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care;
- preservation of private right of action for physicians and other providers and beneficiaries;
- ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization;
- full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan; and
- realistic payment levels based on costs of care and predicted utilization levels.

State Medicaid agencies with Medicaid

managed care programs should disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (H-290.985 [22])

Better measurement, monitoring, and

accountability systems and indices should be developed within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care. (H-290.982 [11])

Medicaid programs and other third party

payers should assure the inclusion of risk adjustment mechanisms in capitation rates to physicians providing care to chronically ill children and adults enrolled in managed care plans. (H-285.957)

The principles contained in this publication have been abstracted and summarized from the AMA Policy Database as follows: Current Ethical Opinions E-6.03, E-8.045, E-8.052, and E-8.054; and House of Delegates Policies 70.937, 140.941, 140.942, 140.978, 160.935, 165.903, 165.908, 165.909, 165.951, 180.956, 190.959, 190.964, 190.965, 190.969, 190.976, 190.978, 190.981, 190.992, 200.969, 230.975, 285.924, 285.931, 285.934, 285.935, 285.939, 285.940, 285.942, 285.943, 285.944, 285.945, 285.946, 285.947, 285.948, 285.951, 285.952, 285.953, 285.955, 285.957, 285.958, 285.991, 285.920, 285.921, 285.922, 285.925, 285.956, 285.960, 285.963, 285.973, 285.979, 285.982, 285.983, 285.984, 285.987, 285.989, 285.991, 285.994, 285.995, 285.996, 285.997, 285.998, 290.982, 290.984, 290.985, 320.948, 320.952, 320.953, 320.968, 320.969, 330.915, 330.916, 330.928, 330.954, 385.938, 385.950, 385.951, 390.878, 400.955, 415.987.

AMA Health Policy Group
Division of Socioeconomic Policy Development
Monica Horton, Editor
Robert D. Otten, Director

www.ama-assn.org/go/healthpolicy

