CHAPTER 2

Medical Records and Managed Care

Chapter Objectives

- Define utilization management and utilization review organization.
- Explain the role of patient information with respect to the utilization management process.
- Compare and contrast the following: HMO, PPO, IPA, GPWW, consolidated medical group, PHO, MSO, foundation model IDS, physician ownership model IDS, PBM, and disease management organization.
- Identify the characteristics of the managed care industry that have changed the nature of patient records.
- Describe the changes in medical records standards made in response to the growth of managed care—whether instituted by legislatures, accreditation organizations, or health information managers.
- Describe the information protected by the HIPAA Privacy Rule and explain how privacy rules affect health plans.

Introduction

Although the medical record originally developed as a business record of individual healthcare providers (primarily hospitals and physicians), it is now a document that supplies health information critical to continuity of care, is subjected to substantial state and federal regulation, and is "owned" as much, if not more, by the patient as by the provider.

Several forces contributed to this transition, including increased emphasis on the importance of documentation in medical training; medical records standards incorporated in accreditation and certification requirements, and the development of formal utilization controls for healthcare services, culminating in the managed care revolution of the late 1900s.

Utilization Review

One factor in the increase in the scope and quality of medical records was a requirement that was beginning to be imposed by payers around mid-century—namely, that providers document the need for, and provision of, services in exchange for payment. The beginning of the Medicare and Medicaid program operations in 1966 was a watershed year for formal utilization review because the program operations required most hospitals and nursing facilities that wished to participate to maintain utilization review programs in order to obtain and maintain certification.[1] In 1972, Congress added an additional layer of review, by professional standards review organizations (later known as peer review organizations and quality improvement organizations),[2] and imposed a specific obligation upon providers to support their provision of services by evidence of medical necessity and quality "in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities."[3] The federal peer review program extended not only to institutions, but also to physicians and other practitioners.[4]

Managed Care

The impetus for the development of utilization review was burgeoning healthcare costs. A related effort by Congress to address quality and

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1 See, e.g., 42 C.F.R. § 482.30, requiring most hospitals seeking to participate in the Medicare program to have in effect a utilization review plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

2 42 U.S.C. § 1320c-3.

3 42 U.S.C. § 1320c-5.

4 42 U.S.C. § 1320c-5.

cost of health care is found in the Health Maintenance Organization Act of 1973, which provided for the development and operation of health maintenance organizations (HMOs), primarily in an effort to ensure appropriate coordination and quality of care, but ultimately to contain rising healthcare costs as well.[5] This legislation laid the groundwork for the managed care revolution.

The concept of "managed care" quickly came to include within its umbrella not only HMOs, but also preferred provider organizations (PPOs), "point of service" plans (POSs), and other entities involved in the coordination and delivery of health care. In 1977, indemnity plans accounted for 96 percent of all job based health plan enrollment; by 1998, indemnity plans held only 14 percent of the market; HMOs held 27 percent; POS plans, 24 percent; and PPO plans, 35 percent.[6]

A fundamental tenet of managed care is that coordination of care will produce higher quality, lower cost outcomes. The pioneering HMO model had sought to furnish most, if not all, covered services required by enrollees "in-house" through physicians employed by, and facilities owned and operated by, the HMO. This approach naturally suggested a comprehensive central medical records database. Other forms of managed care organizations had to obtain information concerning enrollees from a broad range of providers and suppliers in order to coordinate care, and compiling and maintaining a centralized database would prove to be more difficult. To understand the medical records issues that arise in the managed care environment, this chapter discusses below the broad range of managed care entities that operate today.

Managed Care Organizations and Related Entities

The term managed care organization (MCO) is now widely used to encompass various forms of healthcare coordination in the United States.

Health Maintenance Organizations

HMOs are organized healthcare systems that are responsible for both financing and arranging for the delivery of a broad range of

[5] See *Pegram v. Herdrich*, 530 U.S. 211, 233 (2000).

[6] J. R. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny," *Health Affairs* (November/December 1999): 67.

comprehensive health services to a defined population. Some HMOs can be viewed as a combination of healthcare insurer and healthcare delivery system. Whereas traditional healthcare insurance companies are responsible for reimbursing covered individuals for the cost of their health care, HMOs are responsible for arranging for the provision of healthcare services to their covered members through affiliated providers who are reimbursed under various methods. There are different models of HMOs, including staff, group practice, network, IPA, and direct contract, depending on the nature of the relationship between the HMO and its participating physicians. Some HMOs provide a point of service (POS) option, which allows enrollees to use nonaffiliated providers for an additional fee. The HMO models below generally reflect an HMO's relationship with its physicians. The degree of control is described graphically on the following continuum:

Level of HMO Control

Point of Service	IPA	Network	Group Practice	Staff Model
•	•	•	•	•

Less Control — Greater Control

Preferred Provider Organizations

Preferred provider organizations (PPOs) are entities through which employer health benefit plans and health insurance carriers contract to purchase healthcare services for covered beneficiaries from a selected group of participating providers. Typically, providers participating in PPOs agree to abide by utilization management and other procedures implemented by the PPO, and agree to accept the PPO's reimbursement structure and payment levels. In return, PPOs often limit the size of their participating provider panels and provide incentives for their covered individuals to use participating providers instead of other providers. In contrast to individuals with traditional HMO coverage, individuals with PPO coverage are permitted to use non-PPO providers, although higher levels of coinsurance or deductibles routinely apply to services provided by the nonparticipating providers.

Independent Practice Associations

An independent practice association (IPA) is a legal entity, the members of which are independent physicians who contract with the IPA for the sole purpose of having the IPA contract with one or more HMOs. IPAs commonly negotiate with HMOs for a capitation rate that covers all physician services. The IPA in turn reimburses the member physicians, although not necessarily by using capitation. The IPA and its member physicians are generally at risk for at least some portion of medical costs. Therefore, if the capitation payment is lower than the required reimbursement to the physicians, the member physicians must accept lower income. Originally, an IPA was an umbrella organization for physicians in all specialties to participate in managed care. IPAs that represent only a single specialty have also emerged, however.

Group Practice Without Walls

Another type of physician group is the group practice without walls (GPWW), representing a more significant step toward integration of physician services. The formation of a GPWW does not require the participation of a hospital, and, in fact, is often formed as a vehicle for physicians to organize without being dependent on a hospital for services or support.

The GPWW comprises private practice physicians who agree to aggregate their practices into a single legal entity, but the physicians continue to practice medicine in their independent locations. The physicians may appear to their patients to be independent, but from the view of a contracting entity (usually an MCO), they are a single group. The GPWW is owned and governed by member physicians.

Consolidated Medical Group

The terms "consolidated medical group" and "medical group practice" refer to a traditional structure in which physicians have combined their resources into a true medical group practice. Unlike the GPWW, in which the physicians combine certain assets and risks but remain in their own offices and continue to practice medicine as they always have, the true medical group is consolidated into a few sites, and functions in a group setting with a good deal of interaction

among members of the group and common goals and objectives for group success.

Physician/Hospital Organizations

A physician/hospital organization (PHO) is usually a separate business entity, such as a for profit corporation, that allows a hospital and its physicians to negotiate with third party payers. In its simplest and most common version, the participating physicians and the hospital develop model contract terms and reimbursement levels, and use those terms to negotiate with MCOs. Governance of the PHO is typically shared between hospital managers and physicians.

A PHO represents a first step toward greater integration between a hospital and its medical staff. This type of organization has the advantage of being able to negotiate contracts on behalf of a large group of physicians allied with a hospital. Another advantage of a PHO is its ability to track and use data to manage the delivery system, at least from the standpoints of utilization management and quality assessment.

Management Services Organizations

A management services organization (MSO) represents the evolution of the PHO into an entity that not only provides a vehicle for negotiating with MCOs, but also provides additional services to support physicians' practices. The physicians, however, usually remain independent practitioners. MSOs are based around one or more hospitals with the capacity to provide the administrative support that forms the basis for the organization.

In its simplest form, the MSO operates as a service bureau, providing basic practice support services to member physicians, such as billing, collection, administrative support, and electronic data interchanges (such as electronic billing). The physician remains an independent practitioner under no legal obligation to use the services of the MSO on an exclusive basis.

Foundation Model Integrated Delivery System

A foundation model integrated delivery system (IDS) is one in which a tax-exempt organization, frequently a hospital, creates a not for profit foundation that purchases and operates physicians' practices. Depend-

ing on applicable state law, the foundation may be licensed to practice medicine or may be exempt from licensure requirements, and it may employ physicians directly or use hospital funds to purchase the practices directly. The foundation as a subsidiary of a tax-exempt organization usually combines with other affiliated entities to operate an integrated healthcare system. In another model of IDS, the foundation is an entity that exists on its own and contracts for services with medical groups and a hospital. The foundation owns and manages the practices, but the physicians become members of a medical group that in turn has an exclusive contract for services with the foundation. The foundation itself is governed by a board that is not dominated by either the hospital or the physicians and includes lay members.

Physician Ownership Model Integrated Delivery System

The physician ownership model refers to a vertically integrated system in which the physicians hold a significant portion of ownership interest in the healthcare entities that compose the system. In some cases, the physicians own the entire system; in other cases, the physicians own more than 50 percent but less than 100 percent.

Other Managed Care Organizations

Utilization Review Organizations

Utilization management is an essential element of managed care that allows coordination among providers, monitoring of quality, identification of superior or cost efficient providers as well as of inappropriate use of services or facilities, and making medical necessity determinations. Utilization review relies heavily on patient related information. The regulation of utilization review organizations by state legislatures and accreditation associations, including restrictions on the type of medical records information that may be gathered and the uses to which it may be put, has increased significantly over the past decade because of the growing importance of these organizations in managed health care.

Pharmacy Benefits Managers

Pharmacy benefits managers (PBMs) provide managed care services to HMOs, self funded employer group health plans, and government programs. PBMs may be at financial risk for managing the prescription

drug utilization of a defined pool of enrollees, or they may simply contract as third party administrators. PBMs negotiate rebates and price concessions from manufacturers or pharmacies. Generally, PBMs combine a variety of managed care techniques to the delivery and financing of prescription drug benefits. These mechanisms include multitiered drug formularies that require varying levels of financial participation by enrollees, such as higher copayments for brand name pharmaceuticals and lower copayments for generics. In addition, PBMs use prospective, concurrent, and retrospective utilization review in order to ensure appropriate usage. Also, PBMs frequently integrate horizontally and own mail order pharmacies, which reduce dispensing fees.

The Impact of Managed Care on Health Information Management

As the number and complexity of organizations and enterprises involved in the delivery of healthcare services increase, the law of health information management has been forced to develop. Medical records professionals, who traditionally have performed highly quantitative and departmentally focused tasks, must now adopt a systems approach to health information management in a managed care environment. Traditional medical records management activities—such as forms control, record content analysis and control, record tracking, release of information monitoring, record storage, and record destruction—are now performed within large and diverse healthcare enterprises, requiring that decision making and problem solving address the system as a whole. The range of personnel, facilities, and equipment that frequently are connected and supported by an information management system also dictates a more global approach to the subject of medical records and the law.

Traditional legal issues affecting the collection, maintenance, and access to medical records information have evolved with today's healthcare systems, and this information increasingly is being collected and stored electronically. These two trends, increased computer automation and dispersed access to the information, have had, and will continue to have, a profound effect on the legal issues surrounding health information management.

The traditional approach to studying the legal issues associated with medical records has focused on the hospital's role in creating and main-

taining these documents, and much of the early legislation addressing medical records management focuses on hospitals' responsibilities for ensuring that the information gathered is accurate and complete, and that its confidentiality is protected. Medical records case law also frequently deals with hospitals as primary players in the delivery of healthcare services, often involving claims for improper disclosure of information or access to peer review records.

Today, because managed care is the dominant form of health insurance coverage in the United States, the hospital's prominence as the keeper of the medical record is reduced. A patient may consult many healthcare providers—including primary care physicians, specialists, hospitals, laboratories, surgical centers, and rehabilitation centers—and each of them will participate in creating a record for that patient. Records containing healthcare information are held by numerous individuals and entities in different locations, many of which are part of a network of providers established by a managed care plan. The information gathered by these providers needs to be shared for clinical purposes in the interest of optimal care of individual patients. In addition, managed care plans themselves rely heavily on the data gathered in patient records, and the plans accumulate enormous amounts of this kind of information for cost assessment and utilization review purposes. Employers also become part of this data integration, and frequently collect and store patient related information as part of the process of providing healthcare benefits to their employees and documenting workers' compensation claims.

The penetration of managed care into the healthcare delivery system has also been an impetus for the computerization of patient information as data networking becomes necessary to link providers, payers, employers, and consumers both regionally and nationally. Many healthcare reform proposals include recommendations for information system networks that may achieve managed care goals of cutting costs while safeguarding the quality of patient care. The establishment of this type of data exchange ability, however, has raised significant concerns about protecting the privacy of patient information as the control of any individual provider over the release of the information decreases. Healthcare reform proposals also factor into their recommendations the growing difficulty of determining who owns and assumes ultimate responsibility for protecting against unauthorized access to medical records in electronic format.

HIPAA and State Privacy Rules

The passage of the Health Insurance Portability and Accountability Act (HIPAA) and the implementation of the Privacy Rule in 2002 dramatically changed the way entities use and disclose health information.[7] The Privacy Rule governs the use and disclosure of "protected health information" (PHI), a term that generally includes any health information (including payment related information) that is linked to an identifier (such as a subscriber identification number) that could reasonably be used to identify the individual. Most health plans, healthcare providers, and healthcare clearinghouses are "covered entities" subject to the Privacy Rule. (For a detailed discussion of the Privacy Rule, see Chapter 6.)

Although the Privacy Rule does not govern the issue of health information ownership, the rule requires covered entities to respect individuals' rights with respect to PHI about themselves, including the right to access and amend the PHI under certain circumstances. Notwithstanding this focus on individual privacy rights, the current state of the law with respect to the issue of ownership of medical records is generally that the healthcare provider owns the records, which may be released or accessed only in accordance with the law. Some states have begun to respond to the ambiguities that arise in today's managed care setting, where individual providers are in fact employees of larger healthcare organizations. Florida law, for example, provides that "records owner" refers to "any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous record owner; or any health care practitioner's employer, including but not limited to group practices and staff model HMOs, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner."[8] The Florida statute goes on to list certain practitioners and entities that are not authorized to acquire or own medical records, but are authorized to maintain such documents under their respective licensing statutes (for example, pharmacies and pharmacists,

[7] See 45 C.F.R. §§ 160 and 164.
[8] See Fla. Stat. § 456.057(a).

nursing home administrators, clinical laboratory personnel). Record owners as defined in the Florida statute bear the responsibility of maintaining a register of all disclosures of medical records information to third parties.

In addition, with legislation in the majority of states imposing on physicians and other licensed healthcare providers the duty to guard against unauthorized disclosures, state legislatures have had to respond to changes affecting the way health care is delivered and recorded. In a minority of states, legislatures have adopted more generic statutes governing healthcare information. Many states (for example, Tennessee) now impose confidentiality requirements on HMOs,[9] and numerous other states impose similar obligations on utilization review organizations, insurance institutions, agents, and insurance support organizations.[10]

Recognized exceptions to patient privacy in mandatory reporting laws relating to child abuse, infectious diseases, or dangers to third parties generally impose a duty to report certain conditions or events; this duty is imposed on the healthcare provider who is closest to the patient in the treatment relationship. These statutes have been in effect for many years, and many did not contemplate the computerized distribution of patient information that is occurring in today's managed care environment. Increasingly, however, managed care plans are acquiring medical records information that can generate the same duty to disclose information as that imposed on primary healthcare providers such as the physician or the hospital. Nonprovider entities—such as IPAs, utilization review organizations, third party administrators, or employer sponsored health plans—that lawfully access patient care information may be considered "healthcare providers" for the purposes of mandatory reporting obligations, even though they do not directly deliver healthcare services to patients. In Maryland, for example, the definition of "healthcare provider" under the state Medical Records Act includes HMOs and the agents, employees, officers, and directors of a healthcare professional or healthcare facility.[11] Because many managed care plans would fall within the statutory definition of "health maintenance organization," the agents of these plans who work in claims processing, utilization review, or cost or utilization assessments have duties

[9] See Tenn. Code Ann. § 56-32-225.
[10] See, e.g., N.Y. Ins. Law § 4905.
[11] Md. Code Ann., Health-Gen. II, §§ 4-301 through 4-305.

to disclose patient information under specific circumstances and are protected from liability for good faith disclosure actions.[12]

Changes in Medical Records Standards

State regulations and associations that accredit healthcare organizations have also responded to the growing number of entities that collect patient data by elaborating information management standards that apply to the types of healthcare organizations that have emerged in the managed care environment. For example, the National Committee for Quality Assurance (NCQA) accredits managed care organizations, and has elaborated specific medical records standards that apply to this type of organization.[13] In addition, the Joint Commission on Accreditation of Healthcare Organizations accredits many types of healthcare entities—including hospitals, healthcare networks, and preferred provider organizations (PPOs)—and has standards that govern the type of patient related data they collect. For example, the Joint Commission accreditation standards for healthcare networks govern information management, and require that a record of health information contain sufficient information to facilitate continuity of care among the components of the network.[14] The Joint Commission's PPO *Accreditation Manual* also addresses information management, requiring PPOs to determine appropriate levels of security and confidentiality of data and information while at the same time ensuring that they have adequate capability to integrate and interpret data from various sources.[15] Increasingly, the standards governing medical records and health information must consider the roles of a variety of actors and organizations with respect to a multitude of evolving standards addressing the definition, permitted use, ownership, content, access, reporting, and retention of medical records and health information.

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[12] See E. J. Krill, "Required Disclosure of Medical Record Information—Applications to Managed Care," in Monograph 3, *Health Care Facility Records, Confidentialing, Computerization, and Security* (American Bar Association Forum on Health Law, July 1995), 11–26.

[13] National Committee for Quality Assurance, *1997 Standards for Accreditation of Managed Care Organizations,* Standards MR 1 through MR 4. See also National Committee for Quality Assurance, *1997 Standards for the Certification of Physician Organizations,* Standards MR 1 through MR 4.

[14] Joint Commission, *1998–2000 Comprehensive Accreditation Manual for Health Care Networks,* Standard IM 6.3.

[15] Joint Commission, *1997 Accreditation Manual for Preferred Provider Organizations,* Standards IM 1 through IM 4.