

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Subparts J-M

Subpart J--Special rules for MA regional plans, including the establishment of MA regions, stabilization fund, and risk sharing.

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Subpart K--Application and Contract requirements for MA organizations.

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Subpart M--Beneficiary grievances, organization determinations, and appeals.

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Issue Areas/Comments

Subparts J-M

Subpart J--Special rules for MA regional plans, including the establishment of MA regions, stabilization fund, and risk sharing.

The NYT today 8/22 has a front page article describing how blue cross and other insurers have strenuously objected to the Bush plan to divide the country into ten or so large regions in which health insurers would compete for Medicare business. The motive of the Blues is obvious but let's examine their excuses first. The Blues say that their current structure (60 or more plans divided by states or parts of a state) would not allow them to contract with groups of doctors and hospitals across state lines and would not allow uniform pricing in a region. They also say that they do not have the capitol to take on the risks of a multi-state region.

Both these arguments are specious. First, there are already many insurers that contract with doctors and hospitals across state lines, including some of the Blues that have been purchasing other Blues in other states. Regence, for instance, operates Blue plans in Oregon, Utah, Idaho and Washington. Anthem is even larger, having acquired the Blue operations in New Hampshire, Connecticut, Ohio, Maine, Colorado and Nevada. It also operates in other states where it is not the sole Blue insurer. Second, the risk of insurance pool is inversely related to the size of the pool. The larger the pool, the lower the risk, because the risk is spread over more individuals (and more capitol.) The Blues are right in that multi-state regions would require more capitol; that capitol has never been wanting in any other insurance expansion and would not be wanting when the Blues were forced into consolidation by the imposition of multi-state regions.

Why then would the Blues so strongly oppose multi-state regions? The answer lies as always in self-interest; in particular, in the Blues self-interest in preserving the weak regulation and toothless bureaucracies that now regulate them. Insurance companies, including Blues, are regulated by state insurance departments. With fifty state insurance departments, the regulation is so diverse and so fragmented that insurers, including the Blues, can get away with virtually any scheme for pumping up their influence and profits. The imposition of multi-state regions would eventually spell the end of state regulation of the insurance companies and the beginning of a coherent federal scheme to rein in health insurers' ability to operate their business in the least efficient way possible (as efficiency is measured in terms of return on invested dollar, rather than in terms of administrative costs paid out to executives.) Currently, the toothless state regulatory scheme allows health insurers to operate as "old-boy" clubs, perpetuating cozy relationships within the medical-industrial complex that guarantee high salaries to doctors, hospital administrators and insurance executives.

The second answer is closely allied to the first; the Blues and most other health insurers arose from and are still closely tied to the hospital-physician industry. The Blues themselves began as an effort by the hospital and medical industries to guarantee for themselves a steady income in a time when doctors and hospitals were mostly low-paid partly charitable workers. That relationship persists today and attempts to introduce market efficiencies into the medical industry are consistently resisted by the old-boy network (doctors, hospitals and insurers) all crying about how expensive it will be (in the short run.)

Those two reasons are the most cogent explanations for why the Blues are so strongly resisting an approach that in any other industry leads to efficiencies of scale, and in insurance, always decreases the risk by increasing the pool. There are other explanations and other arguments to expose the hollowness of the Blue's opposition, but these will suffice. I am strongly in favor of the imposition of multi-state regionalization of Medicare contracting and agree that such regionalization would lead to increased competition among insurers and enhanced efficiency for invested dollars.

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Category :

Issue Areas/Comments

Subparts A-I

Subpart B--Requirements concerning beneficiary eligibility, election, and enrollment and disenrollment procedures.

We understand BBA requires establishment of "lock-in" however, we question the timing of the initiation of MA and Part D and lock in all in 2006. This will be a confusing time for beneficiaries and we are concerned that with lock in beneficiaries may be more reluctant to make changes or enter managed care plans. There will also be the added burden of educating the beneficiaries about lock in in addition to educating about Part D and the MA changes

Subpart C--Requirements concerning benefits, access to services, coverage determinations, and application of special benefit rules to PPOs and regional plans

Please clarify language with respect to participating/non-participating in Medicare and contracted/non-contracted with the MA organization. In addition, guidance is needed for the provider community with respect to the treatment of a beneficiary who is entitled to Medicare regardless of payer. For example, Medicare participating providers could refuse to treat a MA enrollee because they are not contracted or seek higher payments either from the enrollee or the MA organization yet they are a Medicare participating provider. The PPO model, like the PFFS model will not work if providers are allowed to refuse treatment based on MA enrollment. Many providers do not understand that they must accept what they would have received had the enrollee been on FFS. In other words, MA enrollees continue to have the same rights as FFS beneficiaries.

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Organization :

Category :

Issue Areas/Comments

Subparts A-I

Subpart B--Requirements concerning beneficiary eligibility, election, and enrollment and disenrollment procedures.

please clarify and define cost-sharing and provisions related to involuntary disenrollment. Cost sharing should include coinsurance, copayments, deductibles and premium. in the past health plans have been unable to take any action for failure to pay cost sharing other than premium and the burden of collecting other cost sharing has been the sole responsibility of the provider. if plans are to exercise this option we will need a detailed process to follow before steps are taken to disenroll a memeber. We also understand from our sources at CMS that the action of disenrolling a member for disruptive behavior has hardly, if ever, been used.

Subpart D--Quality improvement program, chronic care improvement program requirements, and quality improvement projects.

Please provide guidelines for identification of participants and measurements and detail regarding the monitoring for improvement.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

ATTACHMENT # 005

Comment on MMA Title II Proposed Regulations

Submitted by Community Health Plan of Washington, September 2, 2004

File code

CMS-4069-P

Issue Identifier

“Subpart A – General Provisions” §422.4 Types of MA Plans

and

“Subpart J – Special Rules for MA Regional Plans”, §422.451 Moratorium on new local preferred provider organization plans

Summary

Community Health Plan of Washington is interested in applying to CMS in 2006 as a new Local HMO that would become operational in 2007. The operational model our Medicaid health plan follows is an HMO, requiring members to select a primary care physician who functions as a “gatekeeper” for referral services. However, we are licensed by the state of Washington as a “health care services contractor.” We do not hold the state of Washington’s licensure designation as a “health maintenance organization”.

We are concerned that since we are not nominally licensed as an HMO, CMS may interpret the language of the proposed regulation in such a way that an organization like ours would not fit the definition of a Local HMO, and rather, would be forced to apply as a Local PPO, thus being subjected to the 2-year moratorium on Local PPOs.

We believe that the intent of the statute and the regulation would be to allow an organization like CHPW to apply as a Local HMO and we ask that CMS consider clarifying the language of §422.4(a)(1)(v) to ensure that an organization like ours would not fall subject to the moratorium.

Detail

Section 221(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA Act”) (Pub.L. 108-173), in establishing the Medicare Advantage Program (the “MA program”) to replace the Medicare+Choice program under Part C, establishes a 2-year (2006-2007) moratorium on the offering of any new local preferred

provider organization (“PPO”) plans. The proposed regulation, at subpart J, §422.451, implements this moratorium.

Section 520(a)(3) of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) added Section 1852(e)(2)(D) defining PPO under the MA program for purposes of quality assurance requirements as including three elements: that the PPO (1) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (2) provides for reimbursement for all covered benefits regardless of whether those benefits are provided within the network of providers; and (3) is offered by an organization that is not licensed or organized under State law as a health maintenance organization (“HMO”). Subpart A of the Part 422, Medicare Advantage Program proposed regulations, at §422.4(a)(1)(v), in defining a coordinated care plan, has included this definition of PPO plan, revising it to read as follows:

“A PPO plan is a plan that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and, only for purposes of quality assurance requirements in § 422.152(e), is offered by an organization that is not licensed or organized under State law as an HMO.”

As stated in the comments to the proposed regulations (FR Vol. 69, No. 148, page 46872), CMS’s intent in proposing this language was to clarify that the application of the more limited quality assurance requirements of Section 1852(e)(2)(B) of the Act applied only to MA organizations not licensed or organized under State law as an HMO. What is not addressed in the comments is the extent to which this proposed definition of PPO plan, when read together with the 2-year moratorium on new local PPO plans, can be interpreted as preventing an organization not otherwise licensed under State law as an HMO from meeting the application requirements of §422.501 of the proposed regulations, i.e., documenting that the organization “is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to MA plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health care services to be offered under the MA contract.”

Given the proposed definition of PPO plan set forth above, we are concerned that unless an organization is licensed or organized under state law as an HMO, it will be presumed to be a PPO plan for purposes of submitting an application for contracting under the MA program, and, where it does not qualify as a Regional PPO plan, will be considered a Local PPO plan and, therefore, barred from applying during the 2-year moratorium.

In our case, we feel that our operational model of assigning members to a primary care clinic, whereby the clinic is capitated and at risk for primary and specialty care, and the primary care provider is responsible for making referrals for specialty care, does not meet the second criterion stating, “...provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers”. Thus, we believe that an organization like ours should, in theory, be able to apply to CMS as a Local HMO. However, as noted above, we are licensed by the state of Washington as a “health care services contractor” (RCW 48.44.010). We do not hold the state of Washington’s licensure designation as a “health maintenance organization” (RCW 48.46.020).

Based on an informal telephone conversation with CMS staff, we believe that the intent of the statute is to allow any managed care plan licensed by its state to accept risk the option of applying to CMS as a Local HMO. We ask that CMS consider clarifying the relevant language to ensure that an organization such as ours would not be precluded from applying to CMS as a Local HMO.

To that end, we have provided two suggestions for sentences that might be added to the regulation to clarify the issue:

- ❑ Any health plan that is licensed by its State to bear risk for primary and specialty care services, that assigns plan members to a primary care provider or primary care clinic, and exposes said provider/clinic to risk for primary and specialty care services may apply as a Local HMO.
- ❑ Any health plan that operates as a Medicaid managed care plan in its state and accepts capitation payments for primary and specialty care may apply as a Local HMO.

Thank you very much for your consideration. If you have any questions, please feel free to contact me:

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Submitter : Michael Celayeta Date & Time: 09/04/2004 06:09:17

Organization : Clinic Pharmacy

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

1. MTMP are direct proactive interventions deisgned to enhance patiens' ability to take medicine correctly and increase patient medication compliance.
2. MTMP is a direct patient care service performed by a pharmacist interaction with a patient and theri medications.
3. MTMP include case management and patient counseling, customized packaging and refill management, and specialized patient medication reminders. Customized packaging must conform to United State Pharmacopoeia standards.
4. MTMP are generally of an ongoing nature, involving an initial patient in-take assessment, followed by routine patient monitoring at regular intervals.
5. MTMP must be reimbursed as a management fee, NOT as a dispensing fee. Costs associated with MTMP are separate and distinct from those costs associated with dispensing.
 - *In-take assessment: 30 - 45 minutes of pharmacists' time per occurrence;
 - *Monitoring and following up: 15 - 25 minutes of pharmacists' time per occurrence.

Submitter : Mrs. Christine Bentley Date & Time: 09/08/2004 06:09:21

Organization : Mrs. Christine Bentley

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

How is CMS protecting enrollees from withdrawal by MA plans much as has been the case with Medicare+Choice? Millions of enrollees were left high and dry, not knowing what to do next.

How can I trust CMA this time when there is no evidence that the MA providers will not "take the additional payments and run".

The burden is not being reduced for original Medicare enrollees who will bear a greater burden. Hence CMA is bringing undue duress on those of us enrolled in it to move to managed care. This will affect my relationships to trusted physicians. Dr. Mark McClelan will be putting his health economics before his medical ethics as he promotes poor continuity of care for many original Medicare enrollees.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Subparts A-I

Subpart B--Requirements concerning beneficiary eligibility, election, and enrollment and disenrollment procedures.

Beneficiaries have sent many prior messages to legislators that they do not support the enrollment lock-in feature. Beneficiary backlash may result from the confusion of Part D and new plan choices in 2006 if they are paired with a feature like "lock-in". Movement of the beneficiary population from FFS Medicare to alternative coverage options may be slowed down in 2006 resulting from the confusion and fear of being "locked-in".

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Organization :

Category :

Issue Areas/Comments

GENERAL

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I am very concerned about the new law that will allow my former employer to drop my coverage. I have been paying premiums since 1969 for insurance coverage for me and my wife. Since my wife will not be old enough to qualify for medicare for another 5 years, I am afraid that if my employer is allowed to drop my coverage, (because I am currently 65) they will also be allowed to terminate my wife's insurance coverage. This will leave her completely uninsured and put us in terrible perdicament.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Subparts A-I

Subpart C--Requirements concerning benefits, access to services, coverage determinations, and application of special benefit rules to PPOs and regional plans

This may not come under the above subpart. In a recent Kiplinger's Retirement Report, there was mention of an initial comprehensive physical exam for new beneficiaries, called the "Welcome to Medicare Physical". I have been a Medicare card carrier since March(this year), but have not used it. Would I come under the "new beneficiaries" now or ever? Would I need to wait until Jan.2005 to have a physical or did I miss the boat by being eligible 9mos too soon? Thank you.

Earlyne Moninger
thewiz37@aol.com

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

It is important that you realize what you are doing to the standard of care that affects PLWA. If you decide to alter this program and put these type of restrictions then you will be setting yourself up for images of pre-care era in the 80's when hysteria and lack of empathy was the chief attitudes of citizens around the world. I propose that you realize what you are about to do. You are going to change the face of a movement and force communities to lose faith in an already frightening administration. We are voters too! Does our vote count and does our quest for a standard of care not part of the Bush agenda. Make me proud of being an american again! Rethink your position on this matter.