America's Health Insurance Plans

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June 2, 2006

Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development--C
Room C4-26-05, 7500 Security Boulevard
Baltimore, Maryland 21244-1850.
Attention: Bonnie L. Harkless

Re: CMS – 10066

Dear Ms. Harkless:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice published on April 5, 2006 by the Centers for Medicare & Medicaid Services in the Federal Register (71 FR 17104) inviting comments under the Paperwork Reduction of 1995 on two notices: "General Notice of Hospital Non-Coverage" and the "Detailed Explanation of Hospital Non-Coverage" and their accompanying instructions. AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. These proposed amendments are of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) program and/or the Medicare cost plan program.

AHIP has consistently supported implementation efforts that promote beneficiary understanding of and access to their appeal rights under the Medicare Advantage and Medicare cost plan programs so that they can take advantage of those rights whenever needed. We believe that there are practical challenges associated with implementation of the proposed rule that are discussed in our comments on the notice of proposed rulemaking. Our comments regarding the related notices are included.

General Comment

- **Medicare Health Plan.** AHIP recommends that CMS use the term "Medicare Health Plan" rather than Medicare Advantage Plan in these notices. These notices apply to three types of health plans: Medicare Advantage plans, Medicare cost plans, and health care prepayment plans. CMS uses the term Medicare Health Plan to encompass these plans in the Medicare & You handbook. In addition, CMS uses Medicare Health Plan in the current "Important Message for Medicare." To be consistent with current usage and to be

accurate, AHIP recommends that CMS substitute Medicare Health Plan for Medicare Advantage Plan in both forms and the instructions.

Generic Notice of Hospital Non-Coverage

General Comment

- **Modified notice for short stays.** In the preamble to the proposed rule (page 17054), CMS raised the possibility of a modified review process for short lengths of stay. We believe that it will be important for CMS to establish such a process and, as needed, develop a modified version of the General Notice for short stays.

Introductory Section

- **Noting physician concurrence with discharge decision.** The introductory sentence in the General Notice of Hospital Non-Coverage states, "Your hospital and/or Medicare Advantage (MA) plan have determined that Medicare probably will not pay for your current hospital stay after the date indicated above." AHIP has two concerns with the language of this sentence:
  + The sentence does not mention the enrollee's doctor, although the doctor must concur that the decision is clinically appropriate. AHIP believes it is important that the beneficiary know that his/her physician was involved in the discharge decision, and we recommend that CMS revise the introductory sentence to appropriately reference the role of the doctor.
  + In addition, we are concerned that the proposed language could be misunderstood by the enrollee, who could believe that coverage of the entire hospital stay is in question.

  One way to address all of these concerns would be to revise the first sentence of the notice to state:

  > Your doctor and your hospital and/or Medicare Health Plan have determined that you can be discharged from the hospital. After the date indicated above, additional days in the hospital will probably not be covered.

  Note: The first sentence of this revised language is adapted from language in the Important Message From Medicare.

How to Ask for an Immediate Review

- **Reference to filing claims with Medicare.** On the second page of the form in the second bullet, the narrative explains that the claim will be submitted to Medicare by the hospital. We do not believe that this information is directly related to the purpose of the General Notice of Hospital Non-Coverage and believe that its inclusion is likely to be confusing to beneficiaries. Therefore, we recommend that this bullet be deleted. If CMS decides to retain this bullet, we note that the language would not apply to Medicare Health Plans and that the bullet would need to be revised so that it would apply to beneficiaries receiving coverage under either Original Medicare or a Medicare Health Plan.

Detailed Explanation of Hospital Non-Coverage

- **Noting physician concurrence with discharge decision.** The introductory sentence in the Detailed Explanation of Hospital Non-Coverage states, "This notice gives a detailed explanation of why your hospital and/or Medicare Advantage (MA) plan have determined that Medicare coverage for your current inpatient hospital services should end." AHIP has a concern with the language of this sentence that is also raised by language in the Generic Notice:
  + The sentence does not mention the enrollee's doctor, although the doctor must concur that the decision is clinically appropriate. As discussed above, we believe it is important that the beneficiary know that his/her physician was involved in the discharge decision, and we recommend that CMS revise the introductory sentence to appropriately reference the role of the doctor.

  One way to address this concern would be to revise the first sentence of the notice to state:

  > This notice gives a detailed explanation of why your doctor and your hospital and/or Medicare Health Plan have determined that coverage for your current inpatient hospital services should end.

- **Source for policy and coverage guidelines.** The bracketed language in the last sentence in the Detailed Explanation requires that the hospital's telephone number be inserted as the number that the beneficiary should call if the beneficiary would like a copy of the policy or coverage guidelines used to make the decision. Since this notice must be delivered by either the hospital or the Medicare Health Plan, AHIP recommends that the

bracketed language be revised to read, "{insert hospital or Medicare Health Plan telephone number}."

AHIP appreciates the opportunity to comment on these draft notices. If you would like to discuss any of the issues we have raised or would like additional information, please contact me at (202) 778-3209 or at cschaller@ahip.org.

Sincerely,

Candace Schaller
Senior Vice President, Regulatory Affairs

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THE MEDICARE COST CONTRACTORS ALLIANCE

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Arnett Health Plans, Inc. (IN) ♦ Blue Cross Blue Shield of Minnesota ♦ Dean Health Plan, Inc. (WI) ♦ Excellus Health Plan, Inc. (NY)
Hawaii Medical Service Association ♦ HealthPartners (MN) ♦ Kaiser Permanente (CA, DC, HI, MD, OH, VA)
M·Plan (IN) ♦ Medica Health Plans (MN, ND, SD, WI) ♦ Medical Associates Health Plan, Inc. (IL and IA)
Medical Associates Clinic Health Plan of Wisconsin ♦ Regence BlueCross BlueShield of Oregon ♦ Regence Blue Shield of Idaho
Rocky Mountain Health Plans (CO, WY) ♦ Scott and White Health Plan (TX)

June 1, 2006

Bonnie L. Harkless
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – C
Room C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-10066

Dear Ms. Harkless:

I am writing on behalf of the Medicare Cost Contractors Alliance (the Alliance) in response to the April 5, 2006, notice in the Federal Register inviting comment on two notices: "General Notice of Hospital Non-Coverage" and the "Detailed Explanation of Hospital Non-Coverage" and their accompanying instructions. The Alliance is a coalition of nineteen Medicare cost plans that currently provide services to approximately 289,000 Medicare beneficiaries who are enrolled in their plans.

As an initial matter, the Alliance recommends that CMS use the term "Medicare Health Plan" rather than "Medicare Advantage plan" in both notices. Medicare cost plans and health care prepayment plans (HCPPs) are required to comply with the appeals and grievances requirements set forth in Part 423 beginning January 1, 2006. Thus, these notices will also be used by Medicare cost plans and HCPPs. The term "Medicare health plan" was used by CMS in the Medicare Managed Care Manual's chapter on appeals and grievances (Chapter 13) to collectively refer to Medicare Advantage plans, Medicare cost plans and HCPPs.

In addition, if CMS decides to have a different notice procedure in the case of short admissions, a separate notice needs to be prepared, consistent with the procedure that CMS ultimately adopts.

We also note that CMS will need to provide instructions to hospitals to indicate to them the circumstances under which Medicare cost plans are not responsible for the appeal.

- **MEDICARE DISCHARGE NOTICE**

The first bullet notes that the hospital or MA plan has made the non-coverage determination. Such language is not appropriate for Medicare cost plans when a non-network provider has referred the member to a non-network hospital and the cost plan may not be aware of the admission (and is not responsible for the appeal). Thus, we recommend CMS develop a form that refers only to the hospital for use in such instances and provide appropriate instructions to the hospital.

In the second bullet on the second page the notice states that the hospital will submit a claim to Medicare. Such language is appropriate for billing option 2 cost plans, but not billing option 1 plans. CMS should ensure that the notice reflects the appropriate party to which the claim will be sent and provide appropriate instructions to the hospital regarding the issue.

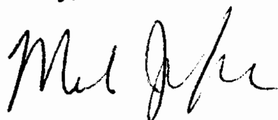
- **DETAILED EXPLANATION OF HOSPITAL NON-COVERAGE**

The first paragraph notes that the hospital or MA plan has made the non-coverage determination. Again, such language is not appropriate for Medicare cost plans when a non-network provider has referred the member to a non-network hospital and the cost plan may not be aware of the admission (and is not responsible for the appeal). To address this issue, CMS could revise the form to refer to the physician as making the non-coverage determination and use this form in all instances. In the alternative, CMS could develop a form that refers only to the hospital in instances where the cost plan is not responsible for the appeal and provide appropriate instructions to the hospital on its use.

The last paragraph includes a place to insert the telephone number of the party to call for policy or coverage guidelines used to make the decision or a copy of the information sent to the QIO. The instructions should specify the instances in which the hospital should insert a Medicare FFS number (when Medicare FFS is responsible for the appeal) and when the cost plan's number should be inserted.

The Medicare Cost Alliance appreciates the opportunity to comment on these proposed rules. If you would like to discuss any of the issues we have raised, please contact me at (202) 457-6633.

Sincerely,



Mark Joffe
Executive Director of the Medicare Cost Contractors Alliance