October 1, 2004

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4068-P and CMS-4069-P
PO Box 8018
Baltimore, MD 21244-8018

Ref. File Code CMS-4068-P and CMS-4069-P

Dear Administrator McClellan:

The Wisconsin Hospital Association (WHA) appreciates the opportunity to comment on the proposed rule implementing the new Medicare prescription drug benefit, published in the August 3, 2004, **Federal Register**.

WHA is a state-wide association of Wisconsin hospitals and health systems, with 132 members. WHA's mission is to advocating for the ability of its members to provide high quality health care services to Wisconsin communities.

The implementation of the new prescription drug and Medicare Advantage provisions will have a significant - and potentially very beneficial - impact on Wisconsin's Medicare beneficiaries. The goal of providing coverage and choice to all beneficiaries is laudable. But we do have a number of concerns and questions regarding how the proposed regulations could affect access to needed services and provider infrastructure, particularly in rural areas.

Before commenting on the rule, it is important to provide some background on Wisconsin's healthcare environment, which is different from the rest of the Country in a number of ways, including:

- ✓ A large component of small rural providers
- ✓ A significant number of integrated delivery systems
- ✓ Effective managed care plans that are parts of these same systems
- ✓ Low cost, high quality providers of Medicare services
- ✓ Historically low Medicare utilization rates
- ✓ Historically underpaid Medicare providers
- ✓ Effective regulatory agencies

Given this almost unique set of circumstances, we have the following concerns:

- ✓ **How will these new rules maintain – even enhance – our healthcare infrastructure?**

- **The rule does not include Critical Access Hospitals (CAH) in its definition of "essential hospital", yet it is the CAHs that have received that designation for all other aspects of the Medicare Program.**
- **Pharmacists in rural communities are not designated as "essential providers", and yet they provide local pharmacy dispensing services as well as typically clinical services within the local community hospital.**

✓ **Will the regulation achieve its goal of providing universal access to all Medicare beneficiaries?**
- **The rule proposes using the "TRICARE" methodology in determining adequacy of access, which could leave many rural beneficiaries without a local pharmacist at "in-network" cost sharing levels.**

✓ **Does the rule help to promote and enhance our provider-sponsored health plans?**
- **The rule sets up a non-level playing field between local and regional health plans. This could have the effect of driving local plans out of the market. The local plans in Wisconsin tend to be provider-sponsored, and have served the purpose of making low-cost, high-quality health insurance available to many in their communities.**

It is unfortunate that Wisconsin beneficiaries, plans and providers continue to be disadvantaged as the proposed benchmarks for the health plans are significantly effected by our state's historically lower utilization rates. Medicare+Choice was rightly criticized for making available extra benefits in regions of the country that had high Medicare utilization which could not be made available in regions with more appropriate utilization.

Finally, as a general comment, there are many aspects of the proposed rule that are left to interpretation, even asking for suggested directions for proceeding. This is much too open-ended a process to then move toward final regulations. We strongly suggest that this comment period be followed by another set of proposed regulations that incorporate the comments from this comment period. This could then be followed by a final comment period.

Our specific comments on the regulations follow.

Title I, Subpart C:

Definition of Rural

WHA is concerned that the definition of rural in the regulations, the Department of Defense's TRICARE's methodology, is much too broad, and could be used to supercede generally recognized standards, such as those used in the Critical Access Hospital program. Such standards have worked well in ensuring access to beneficiaries. The ***Local Community Patterns of Care*** standards outlined in Title II, which include travel times and distances consistent with current usage as measures of access, provide a good model for this definition.

Pharmacy care

The pharmacy benefit provides a much needed addition to the Medicare Program's benefit structure. But if it is not accessible due to distance or monetary barriers, the benefit would be largely illusory.

With this in mind, we propose the following:

- ✓ The provisions in Title II regarding essential hospitals should be applied to essential pharmacies; and the same out-of-network protections for beneficiaries should apply. Beneficiaries should not be required to pay differential charges when using non-network providers for legitimate reasons related to access.

- ✓ Rural beneficiaries must have access to medications in emergency situations and access to the informational services that can only be provided by local pharmacies. Mail order prescription services simply can not provide either of these. CMS must ensure that mail order is not the only option for the rural elderly.

- ✓ Rural pharmacists often serve as the pharmacist/clinician for small, rural hospitals. CMS should ensure that this infrastructure is maintained by requiring plans to contract with pharmacists having this type of relationship with an essential access hospital.

Subpart F:

Fallback Plans

"Fallback" plans, essentially drug-benefit-only plans, will be made available in the event that beneficiaries do not have a choice of enrollment in at least two qualifying plans. WHA expects that, given the anticipated lack of availability of two plans for many rural areas, fallback plans will be the plans of choice. Therefore, since the details about the expected benefits and costs under these fallback plans in comparison with urban based options are not defined, we strongly encourage CMS to fully provide the proposed rules, costs and benefits of these "fallback plans" prior to implementation.

Subpart D:

Cost Control and Quality Improvement

Excellent quality in healthcare is the goal of all providers. The main objective of quality improvement programs is to ensure that the health care system achieves the goal of optimizing the health of the people for whom it is responsible. As health care can vary significantly between urban and rural areas, there needs to be rural appropriate quality healthcare standards and benchmarks that factor in these differences.

The proposed rule suggests that CMS intends to rely on technology to improve quality, even though, at this time, it appears that CMS has not fully funded the grant program in

Section 108 of the MMA. Appropriate funding to rural providers to allow building of an information infrastructure must accompany any such proposal.

Lastly, the quality of care delivered in Wisconsin has traditionally been among the highest in the country. Contributing to that level of quality have been the integrated delivery systems and their related health plans. In fact, several of them have been recognized as national leaders by the National Committee on Quality Assurance and the Baldridge National Quality Program. Our concern is that the regional PPO plans be held to the same high standards as those achieved by our local plans. Because of the monetary incentives provided them, regional plans have the potential of driving local plans from the marketplace. In that event, Medicare beneficiaries should not have to accept a lower level quality of care.

Title II

Subpart C:

Community Access Standard

U**nder no circumstance should the community access standard be relaxed.** This point is paramount to the success of this program in rural America.
Therefore, the current CMS access requirements must be strictly enforced, namely: "Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. <u>This involves ensuring that services are geographically accessible and consistent with local community patterns of care</u>."

The proposed access language, when applied to rural portions of a region, is particularly disturbing. It appears to contradict the access standard noted above of "ensuring that services are geographically accessible and consistent with local community patterns of care." The following language appears to allow rural access to be less than that assured by the "community patterns of care" rule above <u>but falls short of assuring that the beneficiary cost sharing is at "in network" levels</u>. I.e. it allows "less robust" networks to charge higher cost-sharing than charged those "in network," albeit less high than more "robust" networks."

Essential Access Hospital

We would urge CMS to further clarify that, due to the language of the Medicare Modernization Act, the proposed rule's reference to "Essential Access Hospital" does not include Critical Access Hospitals. While CAHs are certainly viewed as essential access hospitals within the rural policy community, they are not defined as such within these proposed regulations. This fact has led to substantial confusion, and will likely cause additional problems within the implementation of this proposal if not further clarified by CMS.

Regional Plan Advantages: Affect on Beneficiaries and on MediGap Plans

WHA is concerned that the proposal could adversely affect rural beneficiaries in the following way:

- ✓ Regional plans are able to offer a more generous set of benefits than local area rural plans because urban benchmark rates make the regional rate higher than local area rural rates.

- ✓ Urban rates which are above the rural floor rates would be weighed in a regional calculation based on numbers of beneficiaries in the affected counties, thereby making the urban rates the dominant component of a regional calculation.

- ✓ Regional plans are able to offer more generous packages than MediGap plans. While the payment will be below historic urban-only rates, it will still enable plans to offer additional benefits, as has been the experience of M+C plans even when rate increases did not keep pace with cost increases.

- ✓ Further, regional plans have other payment advantages, including additional payment within risk corridors when targeted expenses are exceeded, bonus payments up to 3% of the benchmark rate, and assistance in paying essential hospitals.

- ✓ Local area urban plans are able to offer more generous packages than regional plans, because their rates are not lowered by any consideration of the lower rural rates.

- ✓ Local urban markets may be most attractive markets to potential MA plans, which may mean most organizations developing those plans restrict themselves to urban areas. Those decisions, in turn, would limit competition within the remainder of the region to the minimum number of plans required by law. Local MA plans, though, would not receive incentive payments.

- ✓ Choices in rural areas are limited to regional plans and MediGap plans because local rural plans can not compete with regional plans that have higher revenues based on higher rates and financial incentives to induce participation by regional plans. MediGap plans attract only high risk beneficiaries in urban areas, thereby driving up the premiums for all MediGap enrollees in the region.

- ✓ Rural beneficiaries pay a higher premium to enroll in MediGap plans, but the alternatives are limited to whatever regional plans are offered.

Subpart D

Comparable Plan Quality Measures

In response to calls for comments concerning, "comparable measures across plans," WHA urges CMS to collect and review quality data from plans annually. This annual

review is necessary as this program is implemented, and certainly can not be viewed as a one-time occurrence if quality is to be truly measured and ensured.

Subpart E

Relationships with Providers

CMS must incorporate a mechanism for payments to CAHs if the beneficiary is out-of-network. Such a mechanism is necessary in order to provide adequate and timely payment for services rendered in CAHs. We suggest that the payment be the interim rate as set by the Fiscal Intermediary.

<u>Conclusion:</u>

The Wisconsin Hospital Association appreciates the opportunity to submit these comments on the proposed rule. If you have any questions regarding these comments, please contact George Quinn, Senior Vice President, at 608/274-1820.

Sincerely,

Stephen Brenton
President and CEO