CMS Proposes Rules to Curb Marketing Abuses

BY JANE ANDERSON
Contributing Writer

The Centers for Medicare and Medicaid Services, seeking to curtail marketing abuses within Medicare Advantage and Medicare Part D prescription drug plans, has proposed new regulations that would prohibit such tactics as door-to-door marketing and cold-calling of beneficiaries.

The proposed rules, which would incorporate into regulation several requirements that CMS already has imposed administratively, would tighten marketing standards and require independent insurance agents who sell Medicare Advantage and Part D products to be licensed by the state, the agency said.

The rules, which are subject to public comment, also seek to eliminate incentives for agents to "churn" beneficiaries, or persuade people to change plans, to gain enhanced commissions, said Abby Block, director of the CMS Center for Beneficiary Choices, at a press briefing.

CMS plans to roll out the final rule before the fall open enrollment season.

CMS Acting Administrator Kerry Weems said that the proposals "go beyond what the insurance industry recently endorsed as necessary regulatory changes to the program."

However, the House Committee on Energy and Commerce, which has released a report on the Medicare Advantage program, said that the proposed changes "will do little to address the fundamental problems with Medicare Advantage plans."

The rules also seek to eliminate incentives for agents to 'churn' beneficiaries, or persuade people to change plans, to increase commissions.

According to Rep. Bart Stupak (D-Mich.), chairman of the committee's subcommittee on oversight and investigation, the committee's report "has verified countless stories of deceptive sales practices by insurance agents who prey on the elderly and disabled to sell them expensive and inappropriate private Medicare plans." He noted in a statement that the report "shows that steps taken by CMS will not be nearly enough to protect our most vulnerable citizens from deceptive sales practices."

The committee report recommended better sales agent training, strengthened state oversight of plan sales operations, standardization of benefit packages, and comprehensive tracking of beneficiary complaints.

The CMS proposal received mixed reviews from Medicare Advantage stakeholders. Karen Ignagni, president and CEO of America's Health Insurance Plans, said in a statement that the proposed regulations are "an important step to ensure beneficiaries can rely on the information being provided to make the Medicare coverage decisions that are right for them."

Robert Hayes, president of the consumer advocacy group the Medicare Rights Center, said in a statement that the proposed regulations "are inadequate to address the problems we see every day."

Specifically, the proposed standards would prohibit cold-calling and expand the current prohibition on door-to-door solicitation to cover other unsolicited circumstances, such as sales activities at educational events like health information fairs, or in areas such as waiting rooms where patients primarily intend to receive health care–related services, according to CMS.

The regulations also would require Medicare Advantage organizations to establish commission structures for sales agents and brokers that are level across all years and across all product types. Commission structures for prescription drug plans would have to be level across the sponsors' plans as well.

The rule also proposes new protections for those enrolled in special needs plans (SNPs), a type of Medicare Advantage plan that provides coordinated care to individuals in certain institutions, such as nursing homes; those eligible for both Medicare and Medicaid; and those who have certain severe or disabling chronic conditions.

The proposed rules would require that 90% of new enrollees in SNPs be special needs individuals, and would protect beneficiaries enrolled in both Medicare and Medicaid from being billed for cost sharing that is not their responsibility. ■

Feds' Strategic Plan Boosts Electronic Health Records

BY MARY ELLEN SCHNEIDER
New York Bureau

If the feds have it their way, 40% of physician offices will be using certified electronic health records by 2012.

The goal is part of a strategic plan for coordinating the federal government's health IT efforts over the next 4 years, and seeks to further progress toward President Bush's goal, set out in 2004, that the majority of Americans to have access to an electronic health record (EHR) by 2014.

About 14% of physicians had adopted some form of health information technology (IT) by 2007, according to the Office of the National Coordinator for Health Information Technology, which released the strategic plan. Specifically, the plan calls for removing business barriers and disincentives for adoption of EHRs and providing training and technical assistance. For example, the plan says that by next year information on low-cost and effective provider support on EHR adoption should be available online.

The plan also calls for increasing the health IT workforce by training more standards developers, ensuring vendors are trained in the implementation of health IT tools, and training physicians and other health care providers in informatics. It also highlights the need to address physician concerns about liability risks related to the exchange of electronic health information.

In addition to issues related to adoption, the plan lays out goals for achieving patient-focused health care through electronic health record access, and enabling the use of electronic health data to benefit public health, research, and emergency preparedness.

"[The plan] establishes the next generation of health IT milestones to harness the power of information technology to help transform health and care in this country," Dr. Robert Kolodner, national coordinator for health information technology, said in a statement.

The goals are all positive, said Dr. Steven Waldren, director of the Center for Health Information Technology at the American Academy of Family Physicians, but the plan does not place enough emphasis on the need to provide financial incentives to physicians for purchasing and using electronic health record systems.

"The real bottom line is getting the payment reform that is needed in health care today," Dr. Waldren said.

The strategic plan represents a "reasonable approach" going forward and gives a sense of how to achieve the president's objective of greater access to EHRs, said Dan Rode, vice president of policy and government relations at the American Health Information Management Association. But many of the items don't have timetables for completion but will instead be reassessed in 2010, he said, leaving much to be accomplished before 2014.

And while the plan outlines the objectives envisioned by the current administration, the goals and strategies could change with a new president who may be proposing changes to the way health care is delivered, Mr. Rode said. ■

The strategic plan is available online at www.hhs.gov/healthit.

Ready or Not, National Provider Identifier Policy Is Implemented

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Medicare has stopped accepting claims that contain outdated provider identifying numbers, even if the claims also include a National Provider Identifier—despite concerns voiced by physician groups that many are still not ready.

The original deadline for switching to exclusive use of the National Provider Identifier (NPI) was May 23, 2007, but the Centers for Medicare and Medicaid Services gave the medical community another year to prepare.

According to the agency's statistics before the deadline, nearly 99% of claims were already being submitted with an NPI. However, a much lower number, about 37%, were being submitted without a legacy number as well.

Just days before the deadline, members of Medicare's Practicing Physicians Advisory Council voiced their own concerns and tribulations in working toward compliance with the NPI requirements.

"The potential of claims not being paid looms large," said Dr. Arthur Snow, a PPAC member and family physician from Shawnee Mission, Kan.

Previous deadlines, such as the March 1 requirement to use an NPI for all primary provider fields, have already created payment backlogs, said several PPAC members who complained they have dedicated hours of staff time to digging up NPI numbers manually because their software has not been updated to meet the new requirements.

"We went through about 2 months of rejections and the same situation you heard about before where our cash flow went down to zilch. It's been a major, major headache in our office and they're still trying to get those numbers," said PPAC member Dr. Jeffrey Ross, a physician and podiatrist from Houston.

The physicians made several recommendations to CMS staff, such as delaying the move to NPI-only or, at the very least, closely monitoring implementation for potential problems.

The American Medical Association, the Medical Group Management Association, and the American Hospital Association delivered a similar message a couple of days later in a letter to Health and Human Services Secretary Mike Leavitt.

"Although we and our members have worked diligently and invested significant time and resources to comply with the NPI deadline, the health care industry is not well served by terminating the 1 year NPI contingency time frame at this time. Doing so will only make what has been a complex undertaking, an exceedingly disruptive transition," the groups wrote.

The letter cites an analysis by Emdeon Business Services, the nation's largest medical claims clearinghouse, suggesting that as of the end of April, 10% of claims were being submitted without an NPI and close to 70% were carrying a legacy number for a secondary provider, potentially affecting billions of dollars worth of claims for Emdeon alone.

Although it is still too early to know whether the NPI-only policy will lead to delays in reimbursement, there have been few complaints to Medicare so far, according to a Medicare official. ■