Charlene M. Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

By e-mail:

Dear Ms. Frizzera:

The Medicare Rights Center submits the following comments to the draft Advance Notice of Methodological Changes for 2011 and 2011 Call Letter. The Medicare Rights Center is a national, non-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We thank CMS for the opportunity to submit these comments.

Comments on the Advance Notice

Attachment II.

Section F. Adjustment for MA Coding Pattern Differences: We are pleased that CMS intends to adjust for MA plan coding pattern differences again in 2011. By making the coding adjustment, CMS will ensure that Medicare Advantage plans are reimbursed more accurately, particularly with regard to risk adjustments based on the health status of plan enrollees. We also agree that CMS should calculate its coding adjustment by basing it on the expected disease score growth for the period 2007-2011 and by incorporating more recent cohorts of beneficiaries, as described in the Advance Notice.

Section L. Clinical Trial Policy: CMS proposes two changes to the conditions for which CMS will reimburse an MA plan on a fee-for-service basis for enrollee costs related to participation in clinical trials. A plan must reimburse beneficiaries for any cost-sharing related to clinical trial services that exceeds in-network cost-sharing for the same category of services, and the clinical trial cost-sharing must be counted to the plan's out-of-pocket maximum. These two changes will help encourage eligible plan enrollees to participate in clinical trials. We urge CMS to require plans to make such reimbursements based on claims data, without requiring beneficiaries to submit receipts for reimbursement and to automatically add the appropriate cost-sharing for clinical trials toward the calculation of the plan's out-of-pocket limit.

Attachment III.

Section B. LIS Benchmarks: We urge CMS to continue the 2010 demonstration concerning the calculation of LIS benchmarks and to use its demonstration authority to reinstate a de minimis policy for the 2011. These policies have resulted in substantial reduction in the number of LIS-eligible beneficiaries facing reassignment, and possible

disruptions in coverage, when their Part D plan no longer qualifies for a full premium subsidy. .

Attachment IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: We appreciate that CMS chose to use annual percentage increases based on Part D program data and to use revised estimates for annual percentage increases for prior years. As result, Medicare beneficiaries in 2011 will not see an increase increases in the amount of out-of-pocket costs needed to reach the catastrophic threshold.

Comments on Attachment VI: 2011 Call Letter

Section 1. Part D. I. Part D Benefits: We strongly encourage CMS to develop a means to identify ESRD beneficiaries in the dialysis stage to assist Part D plans in determining whether the drugs and biologicals are subject to the MIPPA bundled payment system and therefore are covered under Part B. We are concerned that some Part D plans will use the new bundled PPS system to deny claims automatically, thereby creating access problems for beneficiaries for whom the prescribed medication would still be covered under Part D. It has been our experience that some plans have difficulty in making existing Part B vs. Part D determinations; detailed guidance from CMS has been needed to ensure that plans are able to make those determinations and beneficiaries are not denied medications needlessly.

Encouragement of Sponsor Practices to Curb Waste of Unused Drugs Dispensed in the Retail Setting: We are generally supportive of the proposal to allow beneficiaries who live the community the option to request a trial supply of a Part D covered medication when it is first prescribed. As CMS indicates, the proposal would help curb the waste associated with unused drugs, and it could reduce out-of-pocket costs for beneficiaries who exercise this options. We ask CMS to ensure, however, that plans do not mandate the use of trial supplies for all enrollees as a means to control costs or as part of their expanded use of quantity limits. Beneficiaries who are homebound or who have difficulty getting to the pharmacy would be adversely affected if they were only allowed a trial fill of a new prescription. We would also ask CMS to make explicit requirements to prorate cost-sharing for trial fills and to monitor the cost-sharing charged to beneficiaries under this option. We are concerned that plans might ask beneficiaries to pay more than the proportionate share of the cost.

II. Reassignment: CMS indicates that it is considering expanding reassignment to LIS-eligible Part D enrollees who actively chose their Part D plan ("chooser") MRC supports CMS proposal to reassign "choosers" with a monthly liability of more than $10 if:

1. Only individuals who chose their plan when it was below benchmark are reassigned (this will exclude most beneficiaries who chose an above benchmark plan explicitly for better formulary coverage).
2. Plan reassignment is based on the best formulary match for the individual, with consideration given also to minimizing utilization management. Both the current plan and below- benchmark plans should be vetted for best

match (If current plan provides a better match between the formulary and the beneficiary's drug regimen, the beneficiary would not be reassigned but would receive appropriate notice of their premium liability and their right to select an alternative plan).

3. Plan assignments made by SPAPs would not be overridden.

In addition, we would recommend CMS collect the following data to better inform CMS reassignment process:

1. How many reassigned LIS-eligible beneficiaries actually switch plans from the plans they are automatically assigned?
2. How many choosers switch plans upon receiving a chooser notice?
3. How many choosers are disenrolled from a plan as a result of nonpayment of premiums?

Medicare Rights also recommends use of "intelligent assignment" to ensure the best match between drug regimens and plan formularies for all other reassignments of non-choosers. We recommend that CMS employ secondary criteria for assignment after the best formulary match is identified. Secondary criteria should include plan scores on key quality measures, especially those, such as recognition of enrollee's LIS status and performance measures on handling of Part D appeals, which impact access to medicines. In addition, secondary criteria should include the relative cost to Medicare of alternative assignments based on plan differences in premiums, copay and coinsurance amounts and drug prices. We suggest that CMS look to the reassignment process employed by DEL, the Maine SPAP, as a potential model.

Section II. 2 Updates to parts C and D Policy/Calendar: We ask CMS to require plans to have complete information available on their own web sites and on Medicare Options Compare when those sites becomes live, including information about utilization management restrictions such as prior authorization and step therapy. Beneficiaries cannot make a fully informed choice about prescription drug coverage if they are not informed of all of the requirements to obtain drug coverage. Additionally, information about tiering and cost sharing must be complete and accurate; the information on the web sites must be the same as the information used by plan call centers.

Section VI. Release of Part C and Part D Payment Data: We fully support the release of Part C and Part D plan data as described in the draft Call Letter. As CMS states, the release of such data is necessary to comply with the January 21, 2009 Memorandum on Transparency and Open Government. Additionally, the information is needed to assist researchers in their policy analysis and review of potential new payment policies for Part C and Part D plans, and to assist in the process of detecting waste and misuse of public funds. The information compiled by researchers will help determine the value to beneficiaries of Part C and Part D, including whether and to what extent extra payments are used to provide extra benefits to beneficiaries. We do not believe that the release of the information should have a negative impact on competitive bidding. The information

that will be released will probably not be current enough to inform bids for the next plan years.

Please feel free to contact me if you have any additional questions.

Sincerely,

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