March 4, 2011

Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Via Email: AdvanceNotice2012@cms.hhs.gov

RE: Advance Notice of Methodological Changes for Calendar Year 2012 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter

To Whom It May Concern,

The undersigned organizations appreciate the opportunity to comment on the draft 2012 Advance Notice and Call Letter. Please feel free to contact any of the organizations listed below with questions.

Sincerely,

National Senior Citizens Law Center
Families USA
Medicare Rights Center
Center for Medicare Advocacy, Inc.
California Health Advocates

ATTACHMENT II. CHANGES IN THE PAYMENT METHODOLOGY FOR ORIGINAL MEDICARE BENEFITS FOR CY 2012

Part C: Section A. MA Benchmark, Quality Bonus Payments and Rebate

Pg. 8-9. **Quality Bonus Payment Demonstration/Applicable Percentage Quality Increase.**

As a general matter, CMS is correct to emphasize support for high-quality MA plans. This is consistent with the intent of the PPACA and is a welcome change from past MA payment systems that paid plans without regard to the quality of the plans' performance. While we question the validity of offering bonuses to plans that receive three stars, which is considered "average" according to CMS's own terminology, we understand that it may be appropriate to experiment with policies that encourage plans to improve their quality performance.

At the same time, if the Quality Bonus Payment (QBP) demonstration program is to be helpful in smoothing the transition to a quality-driven MA system, it must be a time-limited, transitional program. The three-year duration of the program (2012-2014) is quite adequate to allow plans to adjust to the MA payment system envisioned under PPACA, under which only 4- and 5-star (i.e. the highest-quality) plans are eligible for quality bonuses. A longer-term demonstration policy could encourage plans to become complacent once they obtain a 3-star, or average, quality rating – something that would not serve beneficiaries' interests.

Moreover, because CMS is proposing elsewhere in the Call Letter to terminate contracts with perennially low-quality 1- and 2-star plans (a proposal we generally support – see our comments below), it is likely that within a few years the vast majority of MA plans will be rated at 3 stars or higher. At that time, the QBP demonstration would be unnecessary to encourage low-quality plans to improve their performance, and payment formulas for quality should revert to those created by the ACA. Continuing bonus payments for 3-star plans at that point would in effect award bonuses to nearly all plans—something clearly not intended by the law.

In response to specific queries in the Call Letter regarding proposed changes to the QBP demonstration, we believe it is not necessary to extend the QBP percentages to the entire blended county rate for plans with fewer than 5 stars. Benchmarks for 3, 3.5, 4, and 4.5 star plans should also not exceed the caps established in the ACA. Because the QBP demonstration is a temporary program, it should not generate payments to plans that result in dramatic reductions in payments when the demonstration ends. If it did, plans could find it difficult to transition to the post-demonstration market. Limiting the scope of the QBPs and abiding by the caps in the law will help prevent this problem.

Pg. 23. **Frailty Adjustment for Fully Integrated Dual Eligible SNPs** (Section M).

We agree with CMS's assessment that frailty measures for SNPs must be done at the plan, not the contract, level, since D-SNPs are likely to enroll populations substantially different from other SNPs or from MA plans within the same contract. (Such an approach would likely be beneficial to the D-SNP.) With respect to scores for new or low-enrollment FIDE-SNPs, we understand that the PACE program has addressed that issue and suggest that CMS follow the PACE model.

Pg. 29 **Calculation Methodology for 2012 Prospective GCDP Payments**

CMS asks whether the calculation of the prospective gap discount payment to Part D sponsors should be adjusted to account for fill fees. As we understand it, fill fees will be included in the amount that beneficiaries are financially responsible for during the coverage gap. Unless plans assume the cost of the fill fees, it would not be appropriate to include the fill fee in the prospective payment to Part D sponsors. Plans should be required to demonstrate that they pay the fill fee and not the beneficiary in order to receive payment in the prospective gap discount payment.

Pg. 37 **Part D Benefit Parameters**

The chart on page 37 does not show $0 cost-sharing for dual eligibles receiving home and community based services. It only reflects $0 cost-sharing for institutionalized dual eligibles. We ask that CMS update the chart to reflect this new benefit.

Pgs. 68 – 76. **Program Updates**

We would like to take this opportunity to encourage CMS to ensure that all important dates, such as when plan information is made available to State Health Insurance Assistance Programs (SHIPs), are adjusted as necessary to ensure that all stakeholders have the information they need in time to begin a smooth, seamless enrollment period. For example, if plan information is not made available in the Plan Finder until October 6, this will provide very little time for SHIPs to prepare for the enrollment period. Previously, SHIPs have some lead time between when plan information is made available and when the enrollment period begins to run test searches to ensure that the information included is accessible and accurate.

We would also like to request that the list of non-renewing plans be made available to SHIPs and other advocates before beneficiaries receive the non-renewal notification letter from the plan. The advance notice would help SHIPs prepare to meet the demand for their services. According to the draft Advance Notice/Call Letter, plans that decide not to renew have a deadline of June 6, 2011 to notify CMS about the decision, and CMS will send an acknowledgement letter by late June. Plans must send a non-renewal notification letter to members by October 3, 2011. If

SHIPs have advance notice of which plans are not renewing by July or August 2011, they can prepare more counselors, sites and other resources to serve more beneficiaries, including those whose plans are not renewing and need help to understand their options.

ATTACHMENT VI: 2012 CALL LETTER

Pg. 74. **Calendar**.

We ask that an October 15 entry be added to the calendar stating: "Plans must post on their website all required translated documents for the 2012 plan year." We also ask that the calendar include an appropriate deadline for plan submission of required translated materials for CMS approval. In light of assertions by many plans on their websites in the last AEP that translations were "coming soon" or waiting CMS approval,[1] we believe that it is important that CMS take additional steps so that limited-English proficient beneficiaries get access to translated materials when they need them during the AEP.

Additional Language Access: The failure in the last AEP of many plan sponsors to post and/or create the translated materials required in current guidance suggests that CMS should add to the Call Letter a specific reminder to plans of their translation and web-posting requirements for marketing materials. We urge the agency to make the addition and suggest that an appropriate location would be on page 106 at the end of Section II.

Pg. 78. **Proposed Initiative to Promote Enrollment in Fully Integrated SNPs.**

We have strong reservations about the proposed initiative to promote enrollment in high quality fully integrated SNPs. We believe that launching such an initiative in 2013 would be premature. Few if any data exist to identify "high quality" Special Needs Plans. SNP Models of Care, required starting in Calendar Year 2010 and a possible first-line indicator of what a SNP offers that is special to its population, are not available to the public, or even to prospective/current enrollees. Moreover, even among researchers little is known about their contents or their execution. (See, e.g., MedPac meeting of February 24, 2011). Quality measures are nearly non-existent – HEDIS measures are, apparently, not available, nor are NCQA process measures. We recommend that CMS concentrate attention on the development and use of plan-level specific quality measures, including measures of family/beneficiary experience (not merely satisfaction) with the plan. Such measures may vary according to the subsets of dual population that the D-SNP is serving.

---

[1]See review of plan websites conducted in November 2010 at www.nsclc.org/areas/medicare-part-d/medicare-plans-not-posting-translated-materials-leaving-spanish-beneficiaries-in-the-dark/

As CMS gathers more data on the performance of existing D-SNPs and FIDE-SNPs, it should include in its evaluations these considerations: 1) that care provided through the plan is patient-centered, based on an individualized assessment and care plan; 2) that beneficiaries are provided real assistance through the plan in actually receiving all care they need that is available from both programs and additional social and transportation services that, e.g., help them stay in their communities; 3) that all providers in the plan are enrolled in both Medicare and Medicaid (or that such enrollment does not matter for them to receive payment); 4) that all enrollees are permitted to retain pre-existing providers who may not be in the plan but with whom the enrollee has an on-going relationship with respect to an on-going treatment plan; 5) that care is actually coordinated by the plan and that all providers in the plan cooperate with care coordination requirements of the plan; 6) that long-term supports and services are provided with maximum focus on keeping beneficiaries in their homes/communities; 7) that beneficiaries have access to providers who speak their language including, as needed, out-of-network providers and that all services are provided in a culturally competent manner.

Flexibilities that could improve the experience for enrollees include a plan being allowed to retain an enrollee in the plan for the entire plan year even if s/he lost dual status mid-way through the year and did not regain it before the end of the year. They might also include some redesign of an appeals process that would give the beneficiary maximum protections of the law without the beneficiary having to determine if her/his appeal should be to Medicare or Medicaid.

We do not understand exactly what CMS means by "seamless enrollment transitions" but we think it might mean passive enrollment of beneficiaries, to ensure a participating plan of substantial enrollment. As we have said on many occasions, initiatives to improve care for dual eligibles must include the protection of free choice by the beneficiary. Given the current SNP landscape, we do not favor initiatives that force duals into plans, even if they have an opt-out protection. Minnesota and Massachusetts have offered integrated plans to duals and achieved successful levels of enrollment without coercion.

We also note that, as of today, there are very few D-SNPs that fully integrate all care components and most are offered by SNP sponsors who first had extensive experience in offering Medicaid managed care. Expansion of FIDE-SNPs, particularly by sponsors without significant experience with Medicaid benefits, especially long term services and supports, needs to be undertaken with caution and care. The challenges vary greatly by state and locality, depending on such factors as the extent to which some services such as mental health and long-term supports have been carved out of the current Medicaid delivery system, the extent to which other care coordination models exist, the availability of providers who participate in Medicaid, etc. We expect that, in many states or localities, full integration would be a multi-step process. We would urge CMS to be sure that any initiatives or incentives around FIDE-SNPs do not have the effect of encouraging plan sponsors or states to telescope steps and processes needed to ensure that robust delivery systems and strong beneficiary protections are in place. The

Medicaid side of the FIDE-SNP equation is where the delivery challenges are greatest and the details of how to effectively deliver services need to be worked out at the state level with local stakeholder input. While we are pleased that CMS is focusing on national beneficiary protection standards for all affected Medicare beneficiaries, we are wary of a top down approach to program design, particularly one that contemplates a preemptive waiver of any existing rules that could have the effect of sidestepping those necessary processes.

Also, in light of the CMMI initiative exploring alternate state models, we ask that CMS not structure initiatives that could have the effect of prejudging the question of whether FIDE-SNPs are the preferred model for care coordination.

Pg. 78. **All Dual Eligible SNPs Required to Contract with State Medicaid Agencies.**

Over the past year, advocates have learned that states have not always engaged in the contracting process with SNPs, that the contracts may be pro forma rather than representational of real negotiation on the part of the state, and not necessarily in the best interest of the beneficiaries. As the requirement for all D-SNPs to have state contracts becomes effective in 2013, we urge CMS to engage in substantive review of the contracts to ensure that the regulatorily-required elements are present and that there is some indication of the state's actual engagement in the process.

Pg. 79. **Involuntary Disenrollment of Ineligible or "Disproportionate Share" SNP Enrollees.** (see also Appendix A-1, pg. 130-1)

We urge CMS to have plans inform their ineligible members well before the October 1, 2011 deadline to which the Call Letter refers so that the individuals have time to seek assistance with the decision of choosing Original Medicare or another plan. Since the plans must report information identifying their ineligible enrollees to CMS by June 30, 2011, the plans could begin notifying individuals at that time.

Regarding both beneficiaries who do not meet and those who no longer meet the criteria to join a SNP, we concur with the decision not to transition them into other non-SNP MA plans offered by the same organization. However, we are concerned that the same MAO is permitted to market other plans to these beneficiaries, even if the marketing is consistent with Medicare Marketing Guidelines. Marketing guidelines for plans that are not renewing allow marketing after October 2, as noted below.

Medicare Marketing Guidelines, §40.9 states: "Plan sponsors may market directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the marketing occurs after the date October 2, the latest date for beneficiary receipt of a plan sponsor's non-renewal letter."

If this limitation applied to those individuals being disenrolled from SNPs, we are assuming, and would like confirmation, that the same MAO cannot include information about its other MA plans or PDPs in the plan's disenrollment letter to the beneficiaries. In the context of non-renewal, we have learned about several cases where beneficiaries, whose plan was not renewing, knew only about the same MAO's other plan(s), did not know about other options, such as other plans from other sponsors or Original Medicare, and thought they had to sign up with that MAO's plan(s).

Whether beneficiaries are disenrolled from a SNP because they no longer meet the definition of a special needs person, because they never did meet each definition, or because their plan is not renewing, we recommend that more be done to ensure that beneficiaries understand that they have other options, including fee-for-service Original Medicare, as follows:

1. Plan's non-renewal or disenrollment notification letter – Emphasize in this letter that there are other MA plans and PDPs available and direct beneficiaries to find out about other plan options on the Medicare website or from their local SHIP. Inform beneficiaries that Original Medicare is an option and include information about Medigap guaranteed issue rights.

2. CMS Non-Renewal Notice (Product No. 11433) or similar product for disenrollments from SNPs – Similarly, emphasize in this notice that there are other MA plans and PDPs available in the beneficiary's area. Inform beneficiaries that Original Medicare is an option. Stress the importance of making an informed decision. Direct beneficiaries to the Medicare website or to contact their local SHIP to get more information.

A propos those individuals who lose their special needs status (in contrast to those who never had it), we believe we understand CMS to be saying in a disproportionate SNP, that the requirement to disenroll non-special needs individuals does not apply during a grace period. This is an important protection for such individuals, most likely dual eligibles, whose dual status often fluctuates over a period of months and whose care would be significantly disrupted if they were in and out of plans each time they gained or lost dual status. We understand that CMS guidance to plans allows the plans to choose any amount of time between one and six months; we urge CMS to encourage plans to choose the longest grace period, i.e., six months.

As noted above, individuals who lose their special needs status and do not regain it during the grace period should be disenrolled from the SNP and told of all their options, including that they will return to Original Medicare if they do not choose another plan.

Pg. 80-81. **MAO and PDP Sponsor Renewal/Non-Renewal Options for 2012**

Several changes could significantly improve the non-renewal process for beneficiaries. We strongly support CMS's initiatives to reduce the number of low-enrollment and duplicative plans

(Pg. 93-94). These policies will continue to simplify and improve the MA and PDP selection process for beneficiaries.

However, CMS's commendable efforts to simplify the MA and PDP marketplace, as well as the conversion of many PFFS plans due to MIPPA requirements, resulted in fall 2010 in a significant number of beneficiaries switching plans through crosswalking for the 2011 year. The crosswalk process generated considerable confusion for beneficiaries and their counselors and advocates. We suggest several improvements to make the process more transparent and understandable for beneficiaries.

a) Do not rely on the ANOC alone to explain changes in plans for a beneficiary being crosswalked. CMS and/or the sponsor should send a special notice to beneficiaries who are crosswalked, in addition to the ANOC. The special notice should inform beneficiaries that they are being crosswalked; and about the plan to which they are crosswalked, especially any differences in premium, cost-sharing and benefits compared to the plan from which they are crosswalked. The special notice should be sent before the ANOC, encourage beneficiaries to read the ANOC for details about the new plan, and emphasize that they may choose a different plan. The notices should also be posted on the CMS website so that beneficiary counselors and advocates have easy access to information about the differences between beneficiaries' old and new plans.
b) Beneficiaries who are crosswalked should get an SEP, because subtle differences between their old and new plans may not become apparent for some time.
c) Make publicly available a list of which plans are being consolidated and which plans the members of disappearing plans are being crosswalked to. The list could be organized by state or region. Such a list would help counselors and advocates determine which beneficiaries are being affected by plan changes and how their plans are changing.
d) Make sure that any crosswalking takes place early in the enrollment period for the next plan year. In fall 2010, we are aware of at least one plan that did its crosswalking in late December. As a result, beneficiaries who had affirmatively chosen a different plan earlier in the enrollment period had that choice overridden by the crosswalk.
e) In the long term, we suggest that MA enrollees who are crosswalked to a new plan should have the same rights as someone whose MA plan withdraws from the market. These rights include guaranteed issue of Medigap coverage if the beneficiary decides to return to original Medicare. We recognize that the consolidation of plans is not a true "termination." However, although the old and new plans may be substantially similar, they are not identical, and an individual beneficiary with specific health care needs may find that her health care needs are now better met through the Original Medicare program plus a supplement.

Pg 82- 83. **Relationship with parent organizations.**

We share CMS' concern about plan ownership and appreciate the pro-active effort to make ownership transparent. We suggest that CMS look to Section 6101 of the Affordable Care Act (ACA) as a model for collecting information on plan ownership and making that information publicly available to SHIPs and through the Plan finder.

Pgs 85-86. **Preventing Part D Payment for Hospice Drugs.**

We agree, in theory, that drugs that would otherwise be covered under Medicare Part A as part of the hospice benefit should not be covered under Part D. However, CMS does not know an individual has elected hospice, revoked the hospice election, or been discharged from hospice until the hospice provider bills for the care. The billing might be delayed significantly, and we have concerns about how quickly CMS can provide this information to the hospice beneficiary's Part D plan. Delays may result in beneficiaries who have been discharged from hospice encountering difficulties in accessing Part D coverage for palliative medications that had previously been covered under the hospice benefit. For people who have recently elected hospice, delays in getting the information to the Part D plan may result in the Part D plan paying inappropriately for medications that the hospice is responsible for and charging the beneficiary cost-sharing. The plan needs to have a process in place to return the cost-sharing paid by the enrollee as quickly as possible once payment reconciliation is made to the plan.

We are also concerned about plans inappropriately denying coverage of non-hospice covered medications. CMS must ensure that plans have systems in place to appropriately delineate what is a hospice covered drug and what is a non-hospice covered drug and make payment accordingly. Otherwise this could turn into a problem similar to that of Part B versus Part D covered drugs in which plans have inappropriately denied coverage for a Part D drug on the claim that is a Part B covered drug.

Pg. 87-90. **Improvements to Plan Ratings**

We support many of the improvements that CMS proposes to make and highly encourage CMS to implement these proposals as soon as possible. For example, we strongly support the inclusion of appropriate implementation of Part D transition processes by plans to ensure continuity of care for beneficiaries and reducing the overall and/or summary plan ratings for contracts with serious compliance issues.

We also recommend that CMS begin collecting and reporting plan ratings at the plan level rather than at the sponsor level. A beneficiary needs to know the quality of the particular plan she or he is considering enrolling in. We also strongly encourage CMS to develop, collect, and report on SNP specific measures. Testimony and discussion at the recent Medicare Payment Advisory

Committee meeting made it abundantly clear that quality measures on SNPs are inadequate and, where they exist, are difficult to use to determine the quality of SNPs. Such measures should also be reported at the plan level and not the sponsor level.

CMS asks, at the top of page 89, for comment on the feasibility of creating a methodology to incorporate SNP-specific measures into plan ratings. CMS uses the term "plan" ratings, but the section discusses ratings at the contract level. Since both are discussed in the document, we want to make clear that we believe SNP ratings must be at the plan level and must be SNP-specific, measuring elements that related to the target population of the SNP.

Pg. 90. **Contracting Organizations with Ratings of Less than Three Stars in Three Consecutive Years.**

We fully support CMS's position that plans that receive one or two stars are not in compliance though we have some concerns about the details of CMS termination plans. Generally, we think three years of non-compliance before a plan is terminated is too long. Keeping a non-compliant plan in the market for three years seems inappropriate and dangerous for consumers. Whether CMS uses three years or a shorter timeframe, we believe the clock should begin in 2009 when the MA sponsors were first put on notice that those plans that receive low star ratings are non-compliant.

We also suggest that, if plans with a one or two star rating are non-compliant, CMS simply use the existing sanctions process rather than creating new rules, and that this process be triggered immediately upon a plan receiving a rating of one or two stars.

We would like to suggest an alternative plan for compliance, that CMS create a probationary period triggered by a one or two star rating in any one year. Under the probationary period, the plan must develop a corrective action plan, which is usually required for most plans under CMS sanction, and from year to year the plan must show improvements on quality ratings. The probationary period would end once the plan achieves a three star or higher rating for two or more consecutive years. If the plan is not able to achieve this goal by the end of the probationary period, then CMS may terminate the contract. The probationary period should not end if a plan achieves a three star rating for one year alone; the plan should be required to demonstrate that it can consistently achieve at least three stars. For instance, if a plan, which is subject to a probationary period, within that probationary period achieves three stars one year but then a below three star rating the next year, we do not believe the timeframe of the probationary period should be reset. The probationary period should not be longer than three years, the suggested timeframe for termination under the original proposal.

Pg. 91. **Special Election Period for Enrollment in 5-Star MA Plans**

While we understand that allowing 5-star plans to enroll year-round serves to encourage plans to achieve higher star ratings and quicken the pace at which plans improve quality, we believe that this SEP could be confusing and detrimental to consumers. We share CMS's goal of improving the quality of MA plans and recognize the goal of the program is good for consumers, but it is essential that the path we take to get there is consumer-centered.

One of the achievements of the ACA was to simplify annual Medicare enrollment periods. Before 2010 and 2011's Fall Open Enrollment Period and Medicare Advantage Disenrollment Period (MADP), there were two annual enrollment periods: one in the fall from mid-October to the end of December and another that began in January and ended in March. The ACA eliminated the second enrollment period. The advocacy community and Members of Congress supported this change because of the excessive and in some cases abusive marketing that Medicare consumers were subject to as a result of what amounted to a six-month enrollment period. Allowing even high quality plans to market year-round in order to encourage enrollment is not in the spirit of this change. Overall, we think this new policy will just serve to confuse consumers who are dealing with an overly and increasingly complex system.

It must be remembered that while Medicare Advantage may be the right choice for some, essentially all plans have restrictions, different coverage rules, different benefit packages and different provider networks. That a plan is five stars may mean that it is high quality, but it does not mean that it is the appropriate choice for all consumers or that the plan's package will meet the needs of every beneficiary. Allowing open enrollment in plans year-round could lead to interruptions in care, especially if people will be required to change doctors, as often is the case when people enroll in a new plan. In addition, if an individual enrolls in a 5-star MA-PD, interruptions in drug regimens can arise because plan formularies and utilization management restrictions vary. While there are adequate protections in place for low-income individuals who have an ongoing SEP if they have Medicaid or LIS, the same type of protections will not be available to those who enroll in 5-star plans using the associated SEP. Namely, if the 5-star plan does not fit an individual's health needs, he or she will be locked into the plan until the next year. However, creating an SEP for disenrollment seems to defeat the purpose of the program and would potentially give other lower-performing plans an opportunity to enroll individuals outside the Fall Open Enrollment Period.

Lastly, this is the first time that stars have been used as a mechanism to reward plans in this manner. It seems more appropriate for CMS to move forward with the Quality Bonus Program as it was set forth in the ACA for at least a short term. CMS could then evaluate the success of the program and its effect on consumers before changing it by offering added incentives.

However, if CMS moves ahead with the proposal as laid out in the Call Letter and the November 2010 HPMS memo, we ask that CMS consider modifications and alternatives to the program currently proposed that would cause the least amount of confusion and disruptions in care for consumers. At the very least, CMS should consider implementing more stringent marketing limitations outside the prescribed enrollment periods.

Whether or not CMS moves ahead with this program, it is imperative that CMS carefully monitor this program to prevent abuses. CMS must ensure that plans that achieve five stars are appropriately using their new authority, and that consumers who are transitioning outside of normal enrollment periods have access to all of the transition protections required by law.

In response to the query in the Call Letter, we strongly oppose expanding the SEP to allow enrollment into 5-star PDPs. Such an SEP would exacerbate beneficiary confusion and further undermine efforts to simplify the enrollment process.

Pg. 92. **Part C Beneficiary Protections: Models of Care for SNPs.**

Nowhere in the beneficiary protections section or elsewhere in the Call Letter is there a requirement for Special Needs Plan to provide their Models of Care to beneficiaries. Beneficiary advocates have repeatedly requested that SNPs be required to provide prospective and current enrollees with a copy of their Model of Care. We request again that the Call Letter include a provision requiring SNPs to make their Model of Care available. Given how much the plans cost, and given that some SNPs do not really provide a benefit package that is "special," potential and current enrollees should have this information so they know what special services the plans say they will provide and the plans can be held accountable. In addition, it is difficult, if not impossible, to measure the quality of a SNP if the Model of Care is unknown. As noted at the recent MedPAC meeting, there is too little information about the SNPs or their Models of Care for duals or chronic conditions to ascertain the quality of care they are providing to their enrollees. The need for the Models of Care is even more important given the proposal to add SNP-specific measures to the plan ratings for 2012 and 2013.

Pg. 96. **CY 2012 Cost Sharing Standards. A. Maximum Out-of-Pocket Limits.**

The discussion of MOOP for D-SNPs correctly acknowledges that the state will be paying cost-sharing on behalf of most enrollees. There could, however, be dual eligibles who receive only state assistance for their Part A or Part B premiums enrolled in the plan and the cost-sharing limits would be relevant to those individuals. All such individuals are near poor and cannot sustain substantial cost-sharing. CMS should scrutinize plans' MOOP and strongly encourage D-SNPs to adopt low voluntary levels of MOOP. Also, discussions of MOOP in plan literature must be clear about to whom the levels apply.

Pg.104. **Multi-year benefits**.

We share CMS's concern that multi-year benefits are confusing to beneficiaries and make plan-to-plan comparisons difficult or impossible. We also believe that having benefits that span contract years can act as a disincentive for beneficiaries to actively compare plans yearly and make choices that best meet their needs. We urge CMS to take a stronger stand with respect to these practices, specifically, that CMS put plans on notice that 2012 will be the last year in which plans may use multi-year benefits and that any such benefit put in a 2012 plan year benefit package may only span two contract years.

Pg. 104. **Copayment and Coinsurance for the Same Service**.

Here as well we share CMS's concern about benefit transparency and the ability of beneficiaries to make plan comparisons when payment structures are complex. While we appreciate that CMS is considering rulemaking about the practice of charging copays and coinsurance for the same service, we believe that the agency could act through guidance immediately to end the practice, as it did with reference-based pricing, and urge CMS to do so.

Pg. 105. **Changes to 2012 Summary of Benefits Regarding Dual Eligible SNP Cost Sharing**.

We appreciate that CMS will be changing the Statement of Benefits for D-SNPS to accurately reflect beneficiary cost-sharing. We continue to urge that all duals, not just those in D-SNPs, get personalized notice of their true cost-sharing obligations.

III. PART D

Pg. 106. **Generic Samples Paid for Through Part D Sponsors' Administrative Costs**

We agree with CMS that, in general, Part D enrollees should be encouraged to use generic drugs when use of generic drugs is medically appropriate. We are concerned, however, that this provision will encourage plan sponsors to increase utilization management requirements and may result in access problems for enrollees for whom generic equivalents are not medically appropriate, particularly with regard to medications within the 6 protected classes of drugs. Additionally, enrollees who are successfully using one generic drug may be forced to change to a different drug because the plan receives a financial benefit from distributing samples of the second drug, which can be charged to administrative expenses, rather than having to pay for a portion of the cost of the first generic drug.

On page 107, CMS says "…Part D sponsors may contract with vendors to provide access to and reporting on generic drug samples as part of their drug utilization management program as an incentive to reduce drug costs by promoting the use of lower cost generic medications…." CMS does not define "vendor." We ask CMS to define vendor to include the medical provider and not

pharmaceutical manufacturers, distributors, or subsidiaries. It would be inappropriate for pharmaceutical manufacturers, distributors, or their subsidiaries to have access to beneficiaries' Medicare Part D prescription drug coverage or prescription drug utilization information.

CMS also says that it will not require reporting of generic samples provided to Part D beneficiaries through PDE reporting or otherwise. We recommend that CMS require reporting either on PDE data or through some other mechanism. This will be important for oversight, as well as to gain a clear understanding of beneficiaries' access to and use of generic drugs.

Pg. 108. **Best Available Evidence and HCBS waiver recipients**.

We appreciate that CMS is reminding plans of the need to have systems in place to recognize BAE for HCBS recipients entitled to zero cost-sharing. We are concerned, however, that the wording in the Call Letter sounds as if BAE might be the only basis on which zero cost sharing will be established. We hope that this is not the case. BAE was always meant to be a safety net, not the primary route to receiving a benefit. We ask that CMS begin early to work with states to ensure that data about beneficiary HCBS waiver participation can be timely transmitted and appropriately recognized so that beneficiaries will automatically get the co-pay status required by ACA, and the BAE policy will be needed only when there is an unusual system failure or delay. We also recommend that CMS provide examples of what would be considered evidence of receipt of home and community-based waiver services.

Pg 108. **Monitoring the Implementation of Transition Policy**

Beneficiary advocates share the concern of CMS that Part D plan sponsors are not implementing properly the transition policy. Many of our clients who are new plan enrollees have not been provided access to their medications and/or not provided access to the exceptions and appeals process, as required under CMS transition policy. We ask that implementation of the transition policy be given heightened importance when determining plan quality ratings, particularly for MA-PD plans that are eligible for increased payments based on high quality of care.

Pg. 109. **Medication Therapy Management (MTM) Services and Racial Disparities**

One possible way to address racial disparities in MTM eligibility criteria may be to base eligibility for MTM services on the types of medications an enrollee uses. For example, such criteria could take into account categories and classes of medications used to treat illnesses and conditions that are more prevalent in certain populations. Individuals who take such medications could be eligible for MTM services even if their utilization does not meet current MTM standards.

Another option would be to make a determination of eligibility for MTM based on the diagnosis and history of non-compliance with prescription drug regimens. Patients in these populations

often do not fill the prescriptions given to them by their medical provider. Therefore, it may be difficult to track eligibility for MTM based only on prescription drug utilization.

We also recommend that CMS consider pilots in which MTM services are provided in alternative settings, such as out in the community, rather than in the pharmacy. Some populations are difficult to reach unless the service is provided to them directly in their communities.

Pg. 110. **Low-Enrollment Plans (Stand-alone PDPs only)**

Beneficiary advocates support efforts by CMS to limit plan sponsors to offering plans with sufficient numbers of enrollees to make them viable options.

BENEFIT DESIGN

Pg. 113. **Meaningful Difference in Part D Coverage**

We want to express our ongoing support of CMS' efforts to ensure that beneficiaries have access to Part D plans that are meaningfully different. Ensuring that plans are meaningfully different limits beneficiary confusion when trying choice among a wide variety of Part D plans.

Pg. 114. **Co-pay Thresholds for Cost Shares**

We appreciate that CMS will again take closer scrutiny of plan benefit packages to ensure that there are meaningful differences among plan benefit packages and to ensure that plan benefit packages do not discourage enrollment by certain beneficiaries. We also appreciate that CMS has requested plans to consider co-pay thresholds in their benefit designs, and is moving to develop such thresholds for benefit packages that do not utilize a three-tier copay design. On page 116, CMS says that "Sponsors not meeting our targets will be asked to amend or withdraw their PBPs," we ask CMS to clarify that if plans fail to do so, that the bid will be denied.

We ask CMS in its analysis of cost sharing based on tiers to also consider cost-sharing based on use of network versus non-network pharmacies. Many beneficiaries are misled into choosing a drug plan based on a tiering structure without also analyzing how cost sharing changes based on the pharmacy they choose. The primary example is the Humana-Wal-Mart plan, which has very low cost-sharing if a beneficiary uses a limited number of network pharmacies but which has cost-sharing that exceeds the CMS standards if a beneficiary uses a non-network pharmacy. We do not believe that a plan should be considered to comply with the standards established in the Call Letter if the cost-sharing applies only to a limited number of pharmacies.

a) We are very concerned that CMS considers a $95 cost share for Tier 3 non-preferred brand name drugs as an acceptable level of cost-sharing. According to the Kaiser Family Foundation, close to half of all Medicare beneficiaries live on incomes at or below 200% of the Federal Poverty Level. The majority of those with incomes over 150% FPL

receive no assistance with their prescription drug costs. Paying $95 towards the cost of a non-preferred drug each month therefore will make the drug out of reach for many people, which in and of itself appears discriminatory. Those for whom there are no lower-tiered alternatives may go without medication. While such individuals may be able to ask for a tiering exception, the exception process is very burdensome for beneficiaries, and CMS appeals data show that the tiering exception process is underutilized. We ask CMS to determine whether the existing levels of cost-sharing for the 50th percentile and above is already discriminatory before basing future discriminatory analyses on the existing cost-sharing amounts. It would be helpful to know which drugs end up on Tier 3 at the higher cost sharing levels and whether these drugs are used for particular conditions, such as diabetes.

b) We are also concerned because some non-preferred drugs that are placed on higher tiers may cost less than the copay assigned to the tier. We ask CMS to scrutinize plan structures closely to ensure that no drug is placed on a cost-sharing tier that exceeds the actual cost of the drug. The Part D benefit is still very complicated for beneficiaries to analyze. Beneficiaries become confused when they see that their expected cost-sharing exceeds the cost of the drug. It is difficult for them to understand the implications of a drug being on the formulary when they pay the full price of the drug. This creates a lot of dissatisfaction with both the drug plan and the Part D drug program.

c) We also ask CMS to look at cost-sharing in the commercial market to ensure that bids submitted by Part D sponsors do not differ substantially in cost-sharing from private market plans, taking into account the increased health care needs and lower income status of the Medicare population.

Pg. 116. **Tier Labeling and Hierarchy**

Beneficiary advocates have long asked CMS to move towards simplification and standardization of Part D plans. However, we believe that allowing plans to submit benefit packages with up to six drug tiers is a step in the wrong direction. The greater the number of tiers, the more confusion there will be for beneficiaries. It is difficult to distinguish among a preferred generic, a non-preferred generic, a preferred brand drug, a non-preferred brand drug, a specialty tier, and an optional category (even if the optional category is limited to excluded drugs). It is virtually impossible to compare drug plans if some have a two tier system, some a 3 tier system, and some a 6 tier system.

CMS is encouraging plans to use the standardized tiering labeling. We ask that CMS require plans to use such labeling. Having all plans use the same tier labeling will help beneficiaries when comparing formularies across plans.

Pg. 119. **Specialty Tier Threshold**

We are very concerned that CMS once again has not increased the dollar amount for drugs that qualify as specialty tier drugs. The price variation of drugs eligible for placement on a specialty tier is very wide, ranging from the $600 threshold to tens of thousands of dollars. Yet utilization data indicate that most specialty-tier claims are for drugs at the lower end of this price range. According to the Government Accountability Office (GAO), the utilization-weighted average of the median negotiated price of all specialty tier-eligible drugs in 2007 was $1,100.[2] This raises questions as to why CMS continues to utilize such a low threshold. Placement on a drug specialty tier can create significant barriers to drug access for beneficiaries. They may be asked to pay more out-of-pocket for the drug than they would if it were placed on a different cost-sharing tier, and they cannot seek a tiering exception for such drugs. We therefore ask (1) for greater transparency in how CMS determines the specialty-tier threshold, (2) for an increase in the specialty tier threshold amount, and (3) for rulemaking to allow plan enrollees to seek an exception for specialty tier cost-sharing.

APPENDIX A-1

Pg 123. **Transitioning of PFFS Plans**

According to the guidance, current enrollees of PFFS plans that are transitioning from non-partial network to partial or full network plans can remain in the plan without having to take any steps to enroll in the plan. We understand that CMS is attempting to minimize disruption for enrollees and to eliminate some burdens on plan sponsors. However, there are substantial benefit design differences for enrollees between non-network and network plans. Individuals in non-network PFFS plans may not be familiar with network requirements; they may not want to remain in the PFFS plan if they are now required to use only network providers. We ask that CMS remind plans that the ANOC must state clearly and prominently that the benefit design of the plan is changing. We further ask that plans be required to send a separate notice explaining the change from non- or partial network to partial or full network, as the guidance requires consolidating PDPs to send to their enrollees (Appendix B-1.6, pg. 149). (See also our comments to pg. 80-81 on non-renewal of plans generally.) Furthermore, we ask that affected enrollees be allowed a special enrollment period to change plans. Although they can change plans during the Medicare Advantage Disenrollment Period (MA-DP), some enrollees may not become aware of the change to a network plan until after the 45-day MA-DP has ended. These

---

[2] The GAO's information was based on prescription drug event (PDE) claims data. See, GAO, *Medicare Part D: Spending, Beneficiary Cost-Sharing, and Cost Containment Efforts for High Cost Drugs Eligible for a Specialty Tier* (Jan.2010) at http://www.gao.gov/new.items/d10242.pdf .

additional protections are crucial as, in our experience, beneficiaries often do not read or understand the complex ANOC they receive during the fall enrollment period.

Pg. 127 ff 10a. **Renewal D-SNP with no state contract that converts to a New D-SNP with Different Designation and a state contract.**

We agree with CMS that in this circumstance, current enrollees would remain in the plan and receive an ANOC. We are, however, aware that the plan with a state contract might be dramatically different from the pre-existing plan without a contract in that the beneficiary enrollee might now be getting all Medicaid benefits through the plan. This might alter her/his care arrangements significantly. Thus, we think notification beyond the standard (now D-SNP specific) ANOC is necessary. Perhaps the ANOC cover letter should contain **bolded** language notifying the beneficiary/enrollee about the Medicaid aspects of the plan benefits and that she/he should pay careful attention.

Pg. 127 10b. **Consolidation of a Renewal Dual Eligible SNP with a D-SNP with a State Contract.**

This situation is similar to the one above for those enrollees in the plan that did not have a state contract. They need a specially focused notice identifying for them that there is a big change in the way they get their Medicaid benefits.

Pg. 128 11. **MAO with a Renewing D-SNP that Also Creates A New Medicaid Subset D-SNP and Transitions Eligible Enrollees into the new Medicaid Subset D-SNP.**

We do not agree that a plan should be able to transition enrollees into the subset D-SNP. The creation of the subset D-SNP happened for a reason; it must be offering a different PBP from the original plan or there would not have been a reason to create it. It is a different plan and beneficiaries should not be just passively enrolled in it. Beneficiaries should receive a separate and specific notice explaining the change and reminding them of their ability to choose a different plan. If the subset is based on a category created by the State Medicaid plan, the State could send a notice to individuals who qualify for the new subset, telling them about it. But the plan should not be able to just move them over to the new D-SNP, nor should the plan be the entity informing them of its existence.

Pg. 129 12. **Renewing D-SNP in a Multi-State Service Area with a SAR to Accommodate State Contracting Efforts in Portions of that Service Area.**

For the enrollees who remain in the service area with the new State contract, we believe the SNP should provide the more specific notice discussed for 10a and 10b, letting them know that they will receive their Medicaid benefits in a different way. Those who are no longer in the D-SNP service area should be treated as no longer eligible for the D-SNP and informed that their plan is

terminating in that service area. Their choices would be the full range of Medicare beneficiary choices – Original Medicare, PDPs and MA plans. If they found value in their D-SNP, they can look for another in their service area.

Pg. 130. **Renewing SNP with Ineligible or "Disproportionate Share" Members.**

Please see comments relating to pg. 79.