

Contract Year 2009 Draft Call Letter

Comment / Response Form

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Org Name	Section	Page #	Description of Issue or Question	Suggested Revision/Comment
Health Assistance Partnership (HAP)				
	Overall comments	all	Need for enforceable rights	The Health Assistance Partnership recognizes and appreciates the additional beneficiary protections added to the 2009 Draft Call Letter. Due to the annual changes made to call letters and contracts, plans often fail to follow guidance and respond to these important changes. We ask CMS to issue regulations that include these beneficiary protections to create enforceable rights for both CMS and beneficiaries.
	Overall comments	all	Timeframe for submitting comments	While HAP is thankful for the opportunity to comment on the 2009 Draft Call Letter, the timeframe provided (2 weeks in which to comment on a 254 page draft of key documents) curtails stakeholder ability to work in a meaningful manner with CMS. Longer comment periods allow thorough and thoughtful input and analysis of the impact of benefit structures on beneficiaries.
	Section A			
	Note on 2009 MA, MA-PD, and Cost Plan Portion of the Call Letter	5	Use of combined ANOC/EOC	We ask CMS not to use a combined ANOC/EOC. The ANOC includes important information about changes in health plan coverage. By itself it is often too dense for many beneficiaries who fail to grasp that their current plan will not be best for them in the following year. Combined with the EOC, the document is too long and too complicated and information about plan changes gets lost.
	2009 MA, MA-PD, and Cost-Based Plan Calendar	8	October 31st date for MA organizations to cease 2008 marketing limited to public media venues	The deadline to cease marketing of CY 2008 plans is currently limited to "public media." We ask CMS to expressly prohibit marketing through sales events and unsolicited marketing events.

	I. Benefit Design, A. Cost Sharing Guidance		MA cost sharing that is greater than Original Medicare cost sharing. 9	We urge CMS to limit MA plans from charging more than Original Medicare cost sharing. Plans that offset their lower cost-sharing by charging more than Original Medicare for the more costly services discriminate against people with greater health care needs. If CMS continues to allow plans to charge more than traditional Medicare for some services, they should require plans to reduce the cost-sharing for these services before the plans are allowed to eliminate or reduce the Part B cost sharing.
	I. Benefit Design, A. Cost Sharing Guidance		9 Indications of potential discrimination	We urge CMS to exercise greater oversight of plan management utilization techniques on Part D offerings. The inability to access prescribed medication through a seamless process is a barrier to accessing care and can result in formulary structures that are discriminatory.
	I. Benefit Design, A. Cost Sharing Guidance		9 Indications of potential discrimination	The bolded language should include references to DME and home health. Many plans charge more than traditional Medicare for those services. If they are not included in the bold language, plans may assume that CMS will not consider it discriminatory if their cost sharing amounts are higher.
	I. Benefit Design, A. Cost Sharing Guidance		9 Indications of potential discrimination	The bolded language reflects areas where benefit structures may lead to discrimination as certain populations are discouraged from enrollment due to costs that are higher than those found in Original Medicare. The specific benefits listed here (renal dialysis, Part B drugs, or skilled nursing facility services) are high-cost services availed of those with serious medical conditions. Due to the objective of CMS examination and the policy of non-discrimination, we urge CMS to prohibit cost sharing that is greater than Original Medicare for these services. Thus the sentence structure would change from "may be considered discriminatory" to "will be considered discriminatory"
	I. Benefit Design, A. Cost Sharing Guidance 1. Out of Pocket Maximum		10 Out-of-pocket maximum limits that do not apply to all services	If an out of pocket limit is not applicable to all services (specifically Part B drugs), CMS should require model language that compares the coverage under the MA plan to coverage under Original Medicare, and the cost to the beneficiary under the MA plan to the cost to the beneficiary under Original Medicare.

	I. Benefit Design, A. Cost Sharing Guidance 1. Out of Pocket Maximum	10	Out-of-pocket maximum	Plans should be required to state in bold that they may charge more for individual services in exchange for offering an out of pocket maximum amount. This is important information for beneficiaries to understand when making comparisons.
	I. Benefit Design, A. Cost Sharing Guidance 3. Cost Sharing for Dialysis Services	10	Dialysis cost sharing equivalent both in and out of area	We appreciate that CMS is requiring plans to offer the same cost sharing for in and out-of-area renal dialysis.
	I. Benefit Design, D. Benefit Clarifications 1. Coverage of OTC Items 1. Catalogs	12	Catalog listings for products covered by Original Medicare	MA plans should be required to list cost sharing amounts for beneficiaries under Original Medicare as compared to cost sharing under the MA plan. This information, in addition to the clear identification that an item is covered through Original Medicare, will reduce confusion and foster transparency as to whether any increased benefit is offered through enrollment in the MA plan. The facilitation of informed choice is met through this combined approach.
	I. Benefit Design, D. Benefit Clarifications 1. Coverage of OTC Items	12	OTCs as part of drug utilization management program	While plans currently use OTC medication as part of their management utilization techniques, we continue to object to these methods. The burden upon providers and beneficiaries to seek an exemption from the step-therapy requirement is incredibly difficult due to the lack of a history of prescribed OTC drugs (since no prescription is necessary). This time consuming barrier to accessing medication as prescribed should be changed when plans shows a preference for OTC drugs as therapeutic alternatives to prescribed medication. We suggest an attestation by the beneficiary at the point of sale stating that the OTC alternative was not helpful and the subsequent ability to override any management utilization technique at the point of sale by the pharmacist filling the prescription.
	I. Benefit Design, D. Benefit Clarifications 2. Incentives and Rewards	13	Grievance by enrollee	We urge CMS to allow an appeals procedure which enables a beneficiary to access rewards/incentives.

I. Benefit Design, D. Benefit Clarifications 3. Transportation	14	Transportation	We commend CMS for drawing attention to the fact that ambulance services are a covered Medicare benefit when certain conditions are met. We ask CMS to take enforcement action against all plans that fail to provide ambulance coverage when the coverage meets the Medicare criteria.
I. Benefit Design, D. Benefit Clarifications 14. Withholding Part C Benefits	16	Withholding benefits	We appreciated CMS' emphasis that plans may not withhold Part C services from enrollees with outstanding bills.
II. Bidding A. General Bidding Guidance	16	General Bidding Guidance	We appreciate that CMS precludes plans from adding referral and prior authorization requirements after the bid is approved.
II. Bidding D. Rebate reallocation	17-18	Rebate reallocation	We appreciate that CMS tells plans they may not allow reallocation rebate reductions by increasing cost-sharing for more limited-use services such as inpatient, skilled nursing facility, and home health care unless other reductions that apply more generally have first been made. However, we question why the first priority of rebate reductions results in a maintenance of the Part D premium. Plans that have to increase their cost-sharing for the more costly services in order to keep a lower Part D premium are still discriminating against sicker beneficiaries who utilize those services. An increased Part D premium in those circumstances would apply to all beneficiaries and therefore would not be discriminatory.
III. Quality and Performance Measures A. HEDIS Reporting	20	Quality improvement	We encourage CMS to enlarge the enrollment criteria for HEDIS reporting. Beneficiaries currently have insufficient information about Medicare Advantage plans to determine whether those plans provide the coordinated care and improved outcomes they promise. Additionally, while low performance on customer service indicators is an important measure, beneficiaries are concerned about outcomes as well. Plans whose chronic care coordination is below par deserve special attention.
III. Quality and Performance Measures C. HOS Reporting	21	Requirements	Given the problems beneficiaries have encountered with PFFS plans, CMS should require these plans to report HOS.

	III. Quality and Performance Measures D. Part C reporting requirements	21	Review of reporting requirements	We are pleased that CMS is developing a set of reporting requirements for Part C contractors. We ask that SHIPs and other beneficiary advocates and assistance centers be given the opportunity to review these requirements before they are made final. We want to ensure that the reporting requirements reflect the information beneficiaries need to make an informed choice between plan options.
	VII. Beneficiary Transition in the Event of MA/MA-PD Contract Termination	23-24	Authority to transition to MA plan	We question CMS' authority to transfer enrollees to another MA plan, particularly if it is offered by a different plan sponsor, if a contract is terminated. The regulations state that when CMS terminates a plan contract effective immediately, it provides notice to enrollees to inform them of their alternatives, including traditional Medicare and other plan options in the area. The regulations do not state that CMS will assign the enrollees to another MA plan. See 42 CFR 422.510(b)(2)(ii). Part C is based on choice. By transferring enrollees to another MA plan, CMS is taking the choice away from beneficiaries. If anything, the default should be a return to traditional Medicare. Beneficiaries who want to remain in an MA plan can use their SEP to choose the plan that is most suitable to them.
	VII. Beneficiary Transition in the Event of MA/MA-PD Contract Termination	24	Continuity of care	"Assuring Continuity of Care" for beneficiary transition plans require an additional factor to those enumerated under this bullet point: access to the same providers and specialists. Due to the difficulty ascertaining specific provider contracts with MA plans, we suggest all transitions should be to Original Medicare with a PDP along with an SEP to join an MA plan or to change to an alternate PDP.
	VII. Beneficiary Transition in the Event of MA/MA-PD Contract Termination	24	Beneficiary education	CMS should require the terminating plan to take all of the steps listed in the interest of beneficiary education. By limiting the plans to "one or more" of the listed steps, it is unlikely that notice to beneficiaries will be actual or effective. The subsequent confusion will be costly for CMS, the plans, and beneficiaries.
	IX. Grievances, Organization Determinations, and Appeals	28	CMS says it will provide "further guidance" regarding the SNP moratorium "to contracting MAs with SNPs."	We ask CMS to make any such further guidance available to all stakeholders.

	X. Special Needs Plans	28-37	SNP	We continue our request that CMS issue regulations defining the requirements for SNPs. While we appreciate the additional details CMS includes in the Call Letter, particularly in regard to the model of care, CMS' own comments about SNP applicants failing to articulate elements of a model of care demonstrate the need for enforceable legal authority.
	X. Special Needs Plans	28-37	SNP	Additionally, we are disappointed that the Call Letter does not include more requirements for plans to explain to enrollees how the benefits the SNP plan offers relate to Medicaid benefits. Plans should not be allowed to charge dual eligible enrollees more than the cost-sharing they would pay under their state Medicaid program. We also believe plans, particularly D-SNPs and I-SNPs that serve primarily dual eligibles, should be required to limit their networks to providers who accept Medicaid and/or who are willing to work within the framework of state Medicaid billing practices.
	X. Special Needs Plans	29-30	Description of Model of Care	We note that CMS has apparently approved "SNPs that do not consistently articulate elements of a model of care" that differentiate the specialized needs of the target population nor corresponding benefits and services geared towards the target population. We are concerned that merely asking plans to "articulate" a specialized model of care does not go nearly far enough to ensure that members actually receive appropriate care. We strongly urge CMS to quickly formulate specific, baseline standards that SNPs must meet in order to hold themselves out as special needs plans, for each of the three different types of special needs populations (duals, chronic/disably, and institutionalized). These requirements should enable prospective members to easily and accurately compare SNPs with alternatives for care, including original Medicare and Medicaid.
	X. Special Needs Plans	30	Description of Model of Care	All SNPs should be required to include the components listed on page 30; they should not be only for consideration
	X. Special Needs Plans	31	Contracts for Medicaid subsets	Information to beneficiaries should reflect the costs that they themselves will have to pay, even if the plan's true cost-sharing will be paid by the state Medicaid program. Plan information should state unequivocally that cost sharing will be limited to cost-sharing the beneficiary currently pays under the state Medicaid program to avoid beneficiary confusion.

	X. Special Needs Plans	35	SNP Enrollment and Disenrollment	We appreciate the clarification that MA plans must continue to provide all plan benefits, including premium and cost-sharing, during the temporary loss of SNP eligibility for duals who lose their dual status.
	X. Special Needs Plans	35	SNP Enrollment and Disenrollment	Continued confusion and misinformation about passive enrollment among beneficiaries, advocates and plan representatives begs CMS clarification of its current policies. It is our understanding that CMS is no longer allowing passive enrollment into SNPs. We strongly support the position of not allowing passive enrollment into SNPs.
	X. Special Needs Plans	35	Deemed Enrollment Periods	We strongly support CMS' explanation that MA organizations must continue to provide all plan benefits, including the same premium and cost-sharing as in the original agreement, during periods of deemed eligibility. We urge CMS also to clarify that MA organizations may not, if an individual reaches the end of deemed eligibility and no longer qualifies for SNP eligibility, make any attempt to seek retroactive reimbursement for the period of deemed eligibility.
	X. Special Needs Plans	35	Deemed Enrollment Periods	We urge CMS to expand the lower limit of the time frame for the deeming period set by the plan. A range of 3 months to 6 months allows for system errors and other errors impacting beneficiary eligibility for Medicaid to be corrected without disruption to beneficiary access to health care.
	X. Special Needs Plans	37	SNP Quality Measures	We urge CMS to develop quality measures for SNPs that relate to the specific needs and standards for the three different categories of special needs beneficiaries, and to prioritize quality measures for dual eligibles, who are currently most often targeted by MA organizations and represent the largest percentage of SNP enrollments.
	X. Special Needs Plans	37	Reviewing 2008 Dual Eligible Medicaid Subset SNP for 2009	We appreciate that CMS is requiring the 2008 dual eligible Medicaid subset SNPs to have a signed contract/agreement with the State in order to offer the SNP in 2009. We believe that all SNPs that serve dual eligibles, including I-SNPs should have some form of agreement with the State in order to coordinate SNP benefits with Medicaid benefits.

	XI. PFFS Plans	37	CMS approach to PFFS vis a vis providers	We are disappointed with CMS' approach to addressing the numerous problems with providers and provider access outlined in the Call Letter. We do not believe that the answer is to require marketing and increased sales activities to providers to induce them to participate in PFFS plans. We believe CMS should engage in increased audits of access to providers, of plan billing and payment, and plan coverage of traditional Medicare services, and to increase enforcement activities when necessary. Given the problems with PFFS plans, we ask CMS to take a more pro-active role in monitoring these plans as opposed to the current deference to plan self-policing and development of systems for identifying early problems.
	XI. PFFS Plans	38	Compliance and Oversight	The overall performance of PFFS plans needs improvement. CMS has touched upon specific areas (provider outreach, provider payment disputes, marketing by agents, disclosure to providers re: medical records) and should include rules in regulations and guidance with more weight. We urge CMS to retain and utilize its authority in oversight and refrain from surrendering responsibility by deference to and reliance upon self-policing by the plans.
	XI. PFFS Plans	38	Training and testing of agents/brokers selling PFFS plans	Unfortunately, agents selling PFFS plans are not the only ones who misunderstand the products they sell. This requirement should be extended to all plans.
	XI. PFFS Plans	38	Training and testing of agents/brokers selling PFFS plans	The training and testing of agents need to include how PFFS/MA/Medicare interact with other kinds of insurance, such as Medicaid.

				<p>CMS is rightly concerned about PFFS plan enrollees' access to providers; if few or no providers in a given area are willing to accept a PFFS plan, it should not be allowed to market in that area; although it is contrary to the great flexibility of PFFS plan design (and the alleged virtues of not having to set up a network of providers), these plans must be able to demonstrate a sufficient number and type of providers who are willing to accept the plan. Heightened scrutiny by CMS is good, but there needs to be a demonstrable threshold that is met, and that plans are required to prove, before they collection of capitated payments. Further, use of a plan's provider outreach program to "use the sales force to educate providers in the plan service area and state provider associations" may undermine the goal of establishing long-term and sustainable provider relationships. The sales force, particularly those contracted instead of in-house, have as their sole goal the enrollment of beneficiaries into plans – they have no allegiance to access to benefits once in a plan.</p>
	XI. PFFS Plans	38	Provider education and outreach	
				<p>We note the irony of asking PFFS plans to monitor their sales agents, while at the same time asking the plans to increase their marketing to providers to encourage enrollment. From the beneficiary perspective we cannot help but be skeptical that the agents will engage in the same misinformation campaign with providers that they use for beneficiaries.</p>
	XI. PFFS Plans	38	Provider education and outreach	
				<p>We ask that SHIPs and beneficiary advocates be given the opportunity to review any model template for PFFS terms and conditions of payment. We ask that CMS not leave to the quality checks to the plans, but engage in oversight of this process.</p>
	XI. PFFS Plans	40	Terms and conditions of payment	
				<p>Any model process for resolving provider payment disputes must include strict time frames for completion. Providers engaged in a lengthy payment dispute resolution process may continue to reject PFFS enrollees, leaving these enrollees without access to care.</p>
	XI. PFFS Plans	41	Model process for resolving provider payment disputes	
				<p>We are disturbed by the burden PFFS plans place on providers. PFFS plans should be prohibited from engaging in more complex medical record requests than are conducted by fiscal intermediaries and carriers in the traditional Medicare program. Plans that impose too significant a burden (pg 43) should be sanctioned.</p>
	XI. PFFS Plans	42	Medical record request	

				Beneficiaries are adversely affected by PFFS plans that require prior authorization for services that would generally be covered under traditional Medicare. Since PFFS plans are not required to report any quality data, there is no way of knowing whether these prior authorization requirements improve the care the PFFS plan provides to its enrollee or reduces costs to anyone other than the PFFS plan. We fail to understand the distinction CMS makes on page 44 between prior authorization and prior notification requirements. Requiring beneficiaries/providers to give notice to the plan before obtaining a service, and allowing the PFFS plan to impose higher cost-sharing if notice isn't provided, is just as burdensome as requiring beneficiaries to get prior approval. If CMS allows PFFS plans to require prior notification, then they must be required to state that requirement in all marketing materials. Further, plans must be precluded from telling beneficiaries that they are different from network plans that require a referral to see a specialist. In both situations the beneficiary has to call the plan, so for all intents and purposes
	XI. PFFS Plans	43	PFFS Prior authorization rules	
	XI. PFFS Plans	44	Performance Data	PFFS plans should be required to participate in HEDIS and in HOS
	Section B.			
	III. Formulary	54-55	Six classes of clinical concern	We greatly appreciate the removal of the exception that allowed plans to require prior authorization for Fuzeon. We also appreciate the clarification that P&T committees must make a decision within 90 days for newly approved drugs within the six classes. Both of these changes help promote access to needed medication.
	III. Formulary	55	Utilization management for antivirals	We support CMS's requirement prohibiting utilization management for antivirals.

	III. Formulary	55	Prior Authorization	<p>We agree that standardization of prior authorization requirements will help streamline formulary review, and that posting approved prior authorization criteria on plan websites will improve transparency. Standardization of prior authorization submissions and the requirement that plans post their prior authorization criteria are important improvements. We urge that CMS require that posting be prominent and in a uniform location across plan sites so that providers and beneficiaries can easily locate them. Also, CMS is proposing to require that plans make the criteria available either from a link when the drug is identified with prior authorization or from a general link on the formulary page. Due to differences in web site design, to meet the purposes of increased transparency the link should be made available in both locations. In addition, the information should be linked to the plan finder. Additionally, customer service representatives should have ready access to prior authorization information and should be required to provide that information, even if the caller is asking only whether a drug</p>
	III. Formulary	57	E. Limited access drugs	<p>CMS reminds sponsors that they may only restrict access to Part D drugs to specialty pharmacies in limited situations. Plans should be required to include these limitations on their formulary pages the same way that they include prior authorization requirements, including the recommendations stated above. We also remind CMS that they should take enforcement actions against plans that needlessly restrict access to drugs in violation of Section 50.3 of Chapter 5 of the Prescription Drug Benefit Manual.</p>
	IV. Part D Benefits	62	Limiting copayments	<p>We agree with CMS that plans are required, by statute, to provide beneficiaries with drugs at a price that is no higher than that negotiated by the plan. Additionally, when the rebate price is lower than the copayment, the price actually paid should be used to determine the initial coverage limit. CMS should monitor this requirement to ensure that beneficiaries are not paying more than they have should be.</p>

	IV. Part D Benefits	62	Ensuring significant differences in approved bids	<p>Advocates have noted what appears to be a real decline in the quality of formularies in benchmark plans for 2008. The need for robust formularies noted in this section is an important one. We ask CMS to review benefit packages very closely. The large number of plans makes comparisons so difficult that choice becomes meaningless. We suggest that CMS limit plan sponsors to submitting two bids, one for basic prescription drug coverage and one for an enhanced plan. We appreciate CMS' concern that benefit packages not have the effect of discriminating against certain types of beneficiaries and ask CMS to monitor benefit designs closely. Plan sponsors that continuously continually submit discriminatory designs should not be allowed to participate in the program.</p>
	IV. Part D Benefits	63	Retail pharmacies offering enhanced coverage in the gap	<p>We urge CMS to require gap coverage availability at all plan contracted pharmacies. The requirement for "sufficient" pharmacies for "reasonable access" is inadequate due to lack of specificity. To ensure that these standards are met, CMS should carefully review marketing materials of those plans that offer gap coverage to ensure that marketing documents sufficiently highlight limits to pharmacy access.</p>
	IV. Part D Benefits	64	Best Available Evidence (BAE)- timeframe for plan sponsors to update systems	<p>We thank CMS for the requirement that BAE is accepted at the point of sale and that subsequent updates to systems occur within 72 hours. We ask that CMS strictly enforce these requirements.</p>
	IV. Part D Benefits	64	BAE- website links	<p>There should be further standardization of web linking requirements that require prominence and that are uniform across plans. All plans should be required to use the same format and terminology for links to key required postings (BAE, transition policy, exceptions and appeals, etc) and those links should appear on the same portion of the same page across plans.</p>
	IV. Part D Benefits	64	Benefit Structure in the Coverage Gap	<p>Beneficiaries are often misled by plan statements that they provide drug coverage in the gap when, in fact, the drug coverage is very limited. We encourage CMS to develop methodologies for determining what is sufficient gap coverage and to strictly scrutinize plan claims regarding gap coverage. Plans that cover only a limited number of drugs should not be allowed to advertise that they provide gap coverage.</p>
	V. Pharmacy Access	66	Terminology regarding "non-preferred" or "other network pharmacies"	<p>We urge CMS to require the use of standardized terminology for all plans.</p>

	VII. Low Income Subsidy Policy	66	Auto-enrollment process	HAP appreciates that CMS recognizes problems with the auto-enrollment system for dual eligibles, and that there is a need to limit auto-enrollments with retroactive dates. It is unclear, however, how CMS will be able to “eliminate the current need for auto-enrollments with retroactive dates by paying all claims for retroactive periods under a separate contract.” We would appreciate public information regarding what this will look like and if plans will be required to follow specific utilization (currently the Wellpoint/POS system use is sporadic and voluntary). Also, clarification as to whether this system will apply to incorrect LIS cost-sharing amounts is sought.
	XI. Compliance/Monitoring	71	Monitoring actions	We applaud more aggressive monitoring of plans and enforcement by CMS.
	XI. Compliance/Monitoring	71	Plan Ratings/Quality and Performance Metrics	We encourage CMS to use the information regarding complaint type, time to resolution, adequacy of resolution (determined through repeat complaints), and systemic adjustments as a result of complaints along with other factors already collected in the Complaints Tracking Module (CTM) to support quality improvement activities.
	XI. Compliance/Monitoring	71-72	Star rating system and the impact of plan performance	We ask CMS to reconsider its rating system. The star system does not provide meaningful information for beneficiaries to compare plans. Rather than additional monitoring of plans with sub-par performance ratings, CMS should preclude those plans from participating in the Part D program. Again, the number of choices available to beneficiaries is so robust that the contract process should be more competitive, with poor performing plans being excluded.
	XI. Compliance/Monitoring	72	Auto-enrollment Readiness Audits	The proposed auto-enrollment readiness audits are an important step to protecting dual eligibles and low income beneficiaries from some of the disruption they face on a yearly basis. We ask CMS to consider moving its auto-enrollment audits to earlier in the year to ensure that plans are truly ready for reassignment and other autoenrollment.

	XI. Compliance/ Monitoring	73-74	2009 Reporting requirements	Adding a report on the number of prescriptions that are immediately filled at the point of sale versus those that are delayed will provide some important new information on plan performance. We believe that this information should be made public both in the aggregate and by plan so beneficiaries and others can analyze plan response to issues and plan response to important beneficiary concerns. In addition we ask that CMS require reporting on the categories and classes of prescriptions that are delayed due to coverage exceptions or prior authorization requirements to ensure that plans are not uniformly discriminating against certain chronic conditions.
	XIII. Security and Privacy Standards	74-75	Plan responsibility if there is a breach in security	Plans should be required to offer one year of credit monitoring services at no cost to the beneficiary if a security breach occurs. Plans should be prohibited from requiring beneficiaries to waive their rights to hold the plan liable for any harm resulting from such breach.
	XV. Change of Ownership	76	Sale of sets of beneficiaries	We agree with CMS's interpretation of the legislative language. Selling sets of beneficiaries undermines active beneficiary choice (it is simply a bait and switch for the enrollee) and takes away any promise of plan stability during the contract year.
	XVI. Beneficiary Transition in the Event of PDP Sponsor Termination	77	Beneficiary transition	Moving beneficiaries to a plan with a similar formulary and benefit structure and with a good performance history is a standard that should be utilized during reassignment of auto and facilitated enrollees. We urge CMS to institute such changes and, to the extent legislative action is needed, to seek the required authority to do so.
	Section C			

	Marketing/ Beneficiary communication	81	Standardized model material	<p>We support CMS's decision to require the use of standardized language in the ANOC/EOC. We repeat our initial comment that these should be separate documents to minimize beneficiary confusion and to highlight the importance of each document, which have separate uses. The ANOC is used by beneficiaries to determine whether they want to remain in their existing plan. The EOC is used to provide detailed plan information once a beneficiary has made the decision about plan enrollment. We appreciate that CMS is requiring the use of standardized model material. We urge CMS to review not only the text but the cover pages, mailers and other portions of any proposed mailings to ensure that they do not convey messages that are inconsistent with the purposes of the ANOC, e.g., messages implying to beneficiaries that there is no need to review their coverage. We are concerned that the File and Use process, without active CMS oversight, will allow such messages to slip through.</p>
	Marketing/ Beneficiary communication	81	Translation of standardized model materials	<p>The absence of translated materials defining plan benefits is a great concern for limited English proficient beneficiaries. We are disappointed that CMS does not address the needs of non-English proficient beneficiaries who speak languages other than Spanish. We request that the Call Letter reference the recent guidance CMS issued on language access.</p>
	Marketing/ Beneficiary communication	81	Standardization- on the web	<p>CMS should mirror its requirement that plans standardize EOC materials by also requiring standardization of key information on plan websites. As noted in our comment to the BAE section, websites should be easily navigable to beneficiaries, physicians and pharmacists. For this to happen, plan websites should have similar structures for key information across plans.</p>

			Quality control Processes for Marketing Development 82 Material	We agree with CMS that plans are “submitting a significant number of inaccurate and incomplete marketing materials” and we encourage CMS’ efforts to “establish processes ... aimed at improving plans’ accountability for the accuracy and completeness of their marketing materials” including attesting to the accuracy and completeness of such material. HAP is still concerned, though, that CMS’ standards for what information must be disclosed is lacking; for example, basic marketing materials should disclose the full range of cost-sharing for a given plan (e.g., for MA plans that charge the same rate as Original Medicare, this should be featured prominently on materials that otherwise highlight the benefits and ignore the drawbacks of plan packages). In addition, MA plans that market towards dual eligibles sometimes include a general – and misleading – comparison chart of how a given plan’s benefits stack up with Medicaid coverage, without regard to the scope of a given state’s Medicaid coverage, which is crucial information needed to decide if enrolling in such a plan would actually benefit a dual eligible.
	Marketing/ Beneficiary communication	82-83	Marketing v. call center activities	We do not object to the clarification. However, CMS should make clear to plans that misinformation by CSRs is as much a marketing violation as misinformation by state licensed marketing representatives.
	Marketing/ Beneficiary communication	83	Agent and Broker Requirements	We agree that agents should be trained. However, we continue to encounter agents who have gone through plan training only to misstate the products they have been trained to sell. We believe plans should be subject to sanctions based on agents’ activities.

	Marketing/ Beneficiary communication	83	Agent and Broker Requirements	HAP is disappointed that the Call Letter provides no meaningful requirements in this area; we believe that CMS should require all MA and Part D plan sponsors to provide a standard <u>training curriculum</u> with accompanying testing by an outside third party. Minimum training should include an overview of Medicare and all types of products (MA, PDP, Medigap) and how Medicare interacts with other coverage such as Medicaid, retiree coverage, VA, etc. and should highlight that individuals with certain kinds of insurance are in danger of losing it if they enroll in an MA or PDP. Training scripts should include clear, unbiased explanations of the coverage options available, including Original Medicare, Medigap supplemental plans, Medicare Advantage, Medicaid and Medicare Savings Programs, as well as marketing guidelines. Training should not be limited to company product lines. In addition, agents should be required to provide information to each prospective enrollee about how to reach their local SHIP program. Ultimately, the training should enable agents to help beneficiaries make the most appropriate choice among
	Marketing/ Beneficiary communication	83	Cooling off period	Agent commissions should be regulated in order to avoid differential commissions between MA and PDP plans that create incentives to sell certain MA plans over PDP plans, regardless of whether it is the best option for an individual.
	Marketing/ Beneficiary communication	84	Increased emphasis on monitoring activities	Plan sponsors must be held accountable for the actions of agents selling their insurance products. When an agent engages in misconduct while selling a plan's product, the plan should be forced to take corrective measures, including the imposition of monetary sanctions against the sponsors and agents. People with Medicare who are harmed by marketing misconduct should be held harmless and any debt incurred should be the responsibility of the sponsoring company.
	Marketing/ Beneficiary communication	84	Increased emphasis on monitoring activities	We are encouraged by CMS' intent to more closely monitor plans' compliance with the Marketing Guidelines; the "multi-pronged approach" references reviews of Complaints Tracking Module (CTM) marketing complaints, although it is our understanding that the CTM is not currently designed to produce specific information, by plan and issue; also, no reference is made to coordination with states, including collection of plan and agent complaint and enforcement actions.

	Marketing/ Beneficiary communication	85	Summary of Benefits placeholder sentence	CMS' allowance of plans to "use the prior year's Medicare premium and deductible amounts instead of waiting for CMS to release the new year's amounts" can lead to significant confusion and uninformed decision-making by beneficiaries; this should not be allowed unless such use is accompanied by explicit warnings that the published figures are for the current year, and that costs will increase.
	Marketing/ Beneficiary communication	85	LIS rider	Finally, CMS should ban sales in senior or disabled housing facilities, and implement reporting requirements that enable plans and CMS to identify and prevent unsolicited door-to-door sales.
	D- Appendices			
	Section 2- List of Plan Providers	99	Optional to include information about providers that accept Medicaid	We ask that the call letter and contract make clearer that plans must identify in their directory Medicare providers that accept Medicaid.
	Introduction	107	Coverage at non-network pharmacies is unclear	Add an example about hospital pharmacies, since they are often not in the network of most plans and many people receive Part D benefits from the hospital pharmacy during a Part B-covered stay.
	Introduction	107	No mention of preferred pharmacies	The concept of preferred pharmacies within a network of pharmacies should be explained in this section.
	Attachment D	111	A partial formulary is not a useful tool for anyone whose drugs are not found on the abridged formulary. It is not sufficient to advise enrollees to call the plan for each drug not listed on the abridged formulary.	Since the abridged formulary must have an alphabetized list of drugs by name in one section of the formulary, we urge you to require plans to include (in this alphabetical list) all drugs on the complete formulary. The earlier sections of the abridged versions may still include tiering and utilization management for each drug. For drugs on the formulary not in the abridged version, the index can offer the member services number or a website. This inclusion would make the abridged version of the formulary much more useful to all and not add significantly to the length of the formulary.
	Attachment D	113	Final sentence under Quantity Limits is confusing.	Limits on the number of doses of a prescription may be applied to the same drug that has a limit of a one or three month supply.
	Attachment D	114	Exceptions section should be emphasized.	The sentences about exceptions should be moved to page 113, directly before the descriptions of types of utilization management.
	Attachment D and E	115, 124- 125	Not clear that a beneficiary must have a physician's statement to request an exception.	Add a sentence that enrollees need a statement from their physicians to request an exception.
	Attachment D	120	Chart instructions not clear	We urge you to remove the italics from the chart instructions.

	Attachment F	132-134		We ask that CMS exercise greater authority over plans' use of the transition letter. SHIPs report seeing few, if any, of these letters and are then unable to assist beneficiaries in working through the exceptions process or changing drugs. This, in turn, causes many more problems at the pharmacy. Please also mention that SHIPs are available to assist beneficiaries who need help with formulary exceptions.
	Attachment J	147	Sentence in bold about changes in coverage are misleading.	Add a sentence that enrollees should consider if their current coverage needs are satisfied by the coverage offered by the plan. If their needs have changed or if the plan's coverage has changed, the enrollees should pay close attention and select a plan that best suits them.
		147-148	No mention of extra help changes in the chart of changes	This chart should have a row that describes the changes to extra help or points those with the LIS to a section that describes the changes to extra help.
		154	Extra bullet	Remove duplicate first bullet point below "What information is included in the EoB?"
		157	Below Paying your monthly plan premium	We encourage you to incorporate the exception about no premium for those with full extra help into the previous sentence.
		158	Need additional bullet point after LEP section	Add bullet that states, You can demonstrate that you were informed that your prescription drug coverage was creditable, when it was not.
		170	Exceptions to network pharmacy rules should be clarified.	Under the header Using network pharmacies to get your prescription drugs, we urge you to describe the exceptions to the network requirements. If you do not describe these exceptions in this section, please add a sentence that directs enrollees to the section that will describe these exceptions.
		172	Formulary rules regarding coverage during retroactive periods is unfair	We urge CMS to consider that transition rules should be in effect for beneficiaries who find themselves retroactively enrolled into a plan, for the entire retroactive period. A beneficiary has no chance of following the formulary rules for a plan that he is enrolled in months after a prescription is filled.
		176	Note to plans with OOP limited	We encourage CMS to ask plans to describe their rules for limited OOP amounts, including all services excluded from the limit.
		203	Sentence about language interpreter is difficult to find, especially for LEP enrollees.	We urge CMS to require plans offering coverage to a population where at least 5% of the population speaks a language other than English, the plan should provide these documents in printed form in that language. In this section of the EoB, this should be printed in each of those languages as well.