March 2, 2012

Marilyn Tavenner, Acting Administrator
Center for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
C1-13-07
Baltimore, Maryland 21244

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2013 Call Letter

Dear Acting Administrator Tavenner:

AARP is pleased to submit comments on the 2013 Advance Notice and draft 2013 Call Letter for the Medicare Advantage (MA) and Part D Prescription Drug programs. AARP is a nonprofit, nonpartisan membership organization that helps people age 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. Older Americans have a large stake in the successful operation of the MA and Part D programs, and AARP provides the following comments on the policy changes proposed in the draft call letter.

We commend the Centers for Medicare & Medicaid Services for its continuing efforts to improve meaningful plan choices for beneficiaries and to mitigate the potential for discrimination against higher-cost individuals in the design of Part C and Part D benefits and cost-sharing requirements. We strongly support the policy changes proposed in the draft call letter to further encourage MA organizations and Part D drug plans to improve performance, and we support CMS' continuing efforts to strengthen the Plan Rating System by refining and adding additional measures. With respect to the *Advance Notice,* we urge CMS to rigorously assess the quality bonus payment demonstration for its impact on access and quality and to continue to enhance value-based payment in the future to reward excellence (and not simply average performance as reflected in the current demonstration of the star rating).

Our comments and concerns about specific sections of the draft 2013 Call Letter are organized consistent with the call letter's sections and follow below:

SECTION 1 – PROGRAM UPDATES

Enhancements to Plan Ratings, 2013 Plan Ratings, and 2014 Plan Ratings

CMS sets out measures, methodologies and thresholds for performance rankings in 2013 and 2014 and notes that it is working on developing a more robust system to measure quality and performance of Part C and Part D contracts. New measures, including a measure of quality improvement, are identified.

AARP COMMENTS: AARP commends CMS for its continuing commitment to improve the Part C and D quality performance measurement system by focusing on improving beneficiary outcomes, beneficiary satisfaction, population health, and efficiency of service delivery. We agree that the three-part aim provides an appropriate framework for this work. We are pleased that the technical specifications will be updated with the most current data. In addition, we support inclusion of CAHPS questions to assess care coordination that specifically examine the role of physicians (and we urge other clinicians) and their responsibility for coordinating care. We also think it will be useful to determine the feasibility of a measure to assess quality improvement. It is important that such a measure be an accurate and fair representation of quality improvement and statistically valid.

HEDIS® 2013 Requirements

CMS proposes to eliminate the 1,000 member enrollment threshold for Part C plans for reporting HEDIS®. All contracts would be required to collect and submit audited HEDIS® summary data to CMS beginning with measurement year 2012. Those submissions are due to CMS on June 15, 2013. CMS is working on a strategy for creating plan ratings for such low-enrollment contracts.

AARP COMMENTS: AARP supports this change in policy to apply HEDIS® requirements to all Part C plans to provide information on the quality of care available to beneficiaries enrolled in such plans regardless of the type or size of plan in terms of its enrollment. Low enrollment plans should be subject to as much if not more scrutiny and HEDIS® measures are one part of the assessment CMS should make to assure adequate plan performance. It is important for prospective members to have plan-specific information about the plans they are considering. However, low-enrollment plans usually do not have sufficient enrollees to report many of the measures. This is a real concern because without performance results, neither CMS nor beneficiaries have adequate information to make necessary decisions. However, at least CMS can look at aggregate scores, and we do see value in having data to assess the program as a whole, even when plan specific determinations cannot be made due to lower enrollment.

Contracting Organizations with Ratings of Fewer than Three Stars in Three Consecutive Years

In 2013, CMS will issue notices to individuals enrolled in plans with fewer than three stars in three consecutive years to alert them to the organization's low rating and offer them an opportunity to contact CMS to request a special enrollment period (SEP) to move into a higher quality plan. CMS advises that low quality plans should expect CMS to apply closer scrutiny to their operations and to initiate action to terminate their contracts following: 1) publication of the set of annual plan ratings that assigns the organization its third consecutive summary rating of fewer than three stars and 2) CMS confirmation that the data used to calculate the star ratings reflect the sponsor's substantial non-compliance with Part C or Part D requirements.

AARP COMMENTS: AARP strongly supports this policy to encourage Medicare Advantage Organizations (MAOs) and Part D plan sponsors to strive for improved performance. Consistent with our comments on last year's draft call letter, we also urge CMS to give higher weight to clinical measures in performance measurement as well as new outcomes derived from patient reports

We are encouraged that CMS is treating plans with fewer than three stars as in need of corrective action to come into compliance with program requirements. We agree that if a plan earns fewer than three stars in the third consecutive year, its contract should be terminated (and have urged that this step be taken after two rather than three consecutive years of poor plan performance). Current enrollees should be alerted to an SEP to switch to a higher quality plan.

Further, we note again our view that CMS should continue to strengthen performance requirements by revising the quality bonus payment demonstration to provide that bonuses are awarded to plans that earn more than three stars. Limited Medicare resources for bonuses are best targeted at higher quality plans.

SECTION II. PART C

CY 2013 Bid Review

A. Cost-sharing, Actuarial equivalence, MOOP limits, Total Beneficiary Cost and Meaningful Difference (MA Plans)

CMS notes that the only changes proposed to the cost-sharing standards for Part C plans are:

- An update to the per day limit on cost-sharing standards for days 21 through 100 of skilled nursing facility care (to $150.00).
- The addition of a cost-sharing standard for urgent care ($65.00).

It further advises that the minimum total out-of-pocket cost (OOPC) difference used to evaluate meaningful difference between plans in a service area, currently set at $20.00 per member per month, will remain unchanged. The maximum out-of-pocket (MOOP) limits and the Total Beneficiary Cost (TBC) change amount (approximately 10% or $36.00 per member per month) will remain the same as CY 2012 and plans will be expected to satisfy the criteria in their initial bid submissions.

AARP COMMENTS: AARP supported the change made by CMS in the last call letter to make explicit each year on a prospective basis MOOP limits for all MA plans and to establish a TBC amount based on historical data. Given recent Medicare cost trends, it seems appropriate to maintain the same TBC change amount as last year ($36 per member per month). We urge CMS to closely monitor plan bids to ensure cost-sharing requirements for individual services do not exceed the mandatory MOOP limits and that the different plans sponsored by a given MAO meet the required meaningful difference criteria. This is important to assure that beneficiaries are given meaningful plan options rather than a large array of plans that do not offer real differences.

In last year's call letter, CMS proposed providing customized enrollee data for both MA and Part D plans so that beneficiaries may more easily compare their expected out-of-pocket costs under different plan options. We anticipate potential challenges in developing these data may exist but urge CMS to move forward in doing so. We note that a health plan comparison tool is available to several federal agencies by CheckBook Magazine. This tool provides an estimate of the likely costs—premiums plus out-of-pocket costs—in a "good" year and a "bad" year with probabilities of each under each plan based on the user's age and other characteristics.

B. MA plans with Low Enrollment:

CMS notes that it now allows plans that have enrollment below the low enrollment thresholds for three years or more the flexibility to submit justifications for renewal. CMS is considering eliminating that flexibility for plans with sustained very low enrollment, e.g., fewer than 25 enrollees, because of concerns about the plans' operational viability and the quality of care they can provide. In implementing this policy, CMS may take into consideration the plan's geographic location, as well as whether the plan has a pattern of growth and if there is reason to expect that enrollment will increase to 100 or 500, depending on plan type, to qualify for renewal.

AARP COMMENTS: AARP strongly supports a policy of terminating plans that fail to meet minimum enrollment thresholds for three or more years, and in particular, those with sustained very low enrollment. Three years is more than ample time for a plan to demonstrate viability. We also urge CMS to impose a high hurdle on a plan seeking to demonstrate its growth potential before exceptions to the termination policy is made.

Supplemental Benefits

During the CY 2012 bid review process, CMS found that some MAOs' cost plan contractors were claiming "services" as supplemental benefits under a coordinated care plan that should already be inherent in that plan model. CMS clarifies which services are considered to be inherent to the coordinated care plan model and thus cannot be offered as supplemental benefits. CMS also notes that Special Needs Plans (SNPs) are expected to provide a higher level of care coordination and disease management as integral to the special care provided to their enrollees. CMS also is concerned about MAOs that have included "disease management" as a supplemental benefit, when such benefits should be considered part of the coordinated care plan model. CMS advises that all MA plans are required under the regulations to provide disease management to a target population under their Chronic Care Improvement Programs. Because some services could be included as "supplemental" benefits that support required disease management activities and programs, and in an effort to increase the transparency of benefit design, CMS provides examples of services that plans could reasonably offer as "supplemental" benefits under an "enhanced disease management" program for CY 2013.

AARP COMMENTS: AARP commends CMS for its efforts to enhance compliance with benefit requirements through the use of specific examples that clarify which services qualify as supplemental and which are inherent to required MA service delivery. We encourage CMS to monitor this area carefully to ensure that the practice of incorrectly classifying certain benefits as supplemental ceases.

AARP urges CMS to consider coordinating Essential Disease Management (EDM) with any medication therapy management (MTM) services provided under Part D. It is possible that, as proposed, EDM and MTM could be duplicative, which could be confusing and overwhelming for qualified enrollees. Also, to further streamline and coordinate these two functions, licensed pharmacists should be included in the definition of "qualified case managers," especially as many pharmacists serve as Certified Diabetes Educators and earn other disease-based credentials.

Special Needs Plans (SNPs)

A. New Benefit Flexibility for Certain SNPs—CMS provides additional information about the type of additional flexibility it would allow to certain fully-integrated dual eligible SNPs (FIDE SNPs) that were first addressed in the October, 11 2011 notice of proposed rule-making. In this Advance Notice certain contract design requirements are delineated. We agree with these but suggest the following additional requirements to ensure that those beneficiaries enrolled in FIDE SNPs receive high quality care. We recommend the requirement that the FIDE SNP be operational in CY 2013 and have been operational in CY 2012 is not long enough to determine whether the plan is a "high performer." While AARP welcomes the opportunity to broaden the scope of services offered to the vulnerable enrollees who would be served by FIDE SNPs, we believe

there must be an established track record to assess before the FIDE SNP is allowed greater flexibility under this provision. In addition, we also recommend that a plan be required to demonstrate it has adequately coordinated with the state Medicaid agency to support seamless Medicare/Medicaid services and that beneficiaries have not reported any problems in this regard.

With regard to the qualifying criteria, we believe eligibility to participate in this expanded, more flexible program should be reserved for plans with more than 3 stars. We believe greater flexibility should be reserved for SNPs that truly excel.

The list of supplemental benefits being considered for this program represents the types of services that will benefit the enrolled population in FIDE SNPs and their caregivers. We are pleased that plans will be required to offer any new supplemental benefits under this provision at zero cost to the beneficiary. AARP commends CMS for recognizing the needs of family caregivers and including services that support them in their caregiving role and are related to the provision of plan-covered benefits. We suggest CMS consider allowing for the provision of non-skilled in-home support services through consumer-directed models of care and allowing enrollees to hire family caregivers to provide such services.

B. Marketing Flexibility for SNPs- We appreciate the need for some marketing flexibility for integrated SNPS that meet the specified criteria. However, we urge CMS to assure that any marketing materials produced under the more flexible requirements are nonetheless reviewed for accuracy, completeness, and ease of enrollee use and comprehension.

C. N/A

D. Revision to the Cure Process for NCQA Approval of SNP Models of Care (MOC)- As we understand CMS's proposed plan, it will be possible for plans earning low scores on the NCQA approval process to participate for one year as it attempts to improve its score. We object to this lenient treatment and believe that if a SNP does not achieve at least two-year approval, it should be considered out of compliance. We believe that SNPs who are responsible for caring for the most vulnerable Medicare/Medicaid beneficiaries must be able to demonstrate they can meet the needs of this population. It is not appropriate to allow SNPS to "cure" their scores at the risk of jeopardizing the health and welfare of vulnerable, frail, sick individuals. We also urge some means of verifying the impact of provisions in MOC described by the plan.

E. Contracts with State Medicaid Agencies- AARP supported the requirement for SNPs to have contracts with state Medicaid agencies as an important means of advancing seamless coordination for dual eligible beneficiaries and to ensure that they receive all the services to which they are entitled in an integrated manner. However, we understand the concern CMS raises in connection with the possibility that some enrollees in SNPs without the required state contracts might be disadvantaged if they

were forced to be disenrolled in the absence of the necessary contract. We assume such beneficiaries would be enrolled in non-SNP MA offerings of the same parent plan. We think it is important that performance information on cost and quality be made available to beneficiaries forced to change plans so they can make informed decisions about their choices.

Private FFS Plans

CMS clarifies how the MOOP limit applies to PFFS plans under two scenarios, depending on whether the provider is deemed/non-contracting and non-participating under Original Medicare participation rules or is deemed or contracted, and whether the balance billing is explicitly included in the plan's contract with the provider or in the terms and conditions of payment.

AARP COMMENT: AARP commends CMS for providing this clarification of how the MOOP applies and the implications for balance billing charges to the beneficiary. It is also important that information about the different balance billing rules be communicated to beneficiaries (both in *Medicare and & You* and in information provided by the PFFS plan to individuals in marketing literature) as well as to individuals once enrolled so they are alerted to their out of pocket cost liabilities under the different circumstances.

SECTION III. PART D

Preferred/Non-Preferred Network Pharmacies

CMS has received reports of beneficiary and pharmacy confusion over whether preferred cost sharing is available at individual pharmacies. CMS says this confusion arises when beneficiaries do not select a specific pharmacy when they compare Part D plans using the Medicare Plan Finder. It proposes to change the Plan Finder as soon as possible to require the beneficiary to select a pharmacy for purposes of providing cost estimates that reflect the selected pharmacy's status as preferred or non-preferred in the plan's network. As a result, the situation would be eliminated where a beneficiary obtains cost estimates and plan selections based on preferred pharmacy cost sharing when he or she does not intend to use pharmacies in the preferred pharmacy network. CMS notes that the selection of a particular pharmacy in Plan Finder for this purpose has no bearing on the beneficiary's ability to fill prescriptions at any network pharmacy.

CMS also proposes that sponsors of Part D plans that offer both preferred and non-preferred cost sharing clearly designate their pharmacy contracts—including their standard terms and conditions available to any willing pharmacy—as either preferred or non-preferred Part D network contracts to improve transparency around these arrangements.

AARP COMMENT: We appreciate CMS's efforts to address the beneficiary confusion that can arise due to preferred/non-preferred network pharmacies. We strongly support requiring Part D plan sponsors to clearly designate pharmacy contracts. We also strongly believe the Plan Finder should clearly indicate which plans use preferred network pharmacies and, if so, warn users that their costs could be higher if they purchase their drugs from non-preferred network pharmacies. We are concerned, however, about the proposed change to the Plan Finder that would require users to designate a preferred pharmacy. At the most practical level, this could be confusing to a beneficiary (e.g., if they use multiple pharmacies). It could also stymie efforts by family members or others to assist a Medicare beneficiary in reviewing their plan options. An alternative would be to allow Plan Finder users to check a box that permits them to say "I'm not sure" with regards to a preferred pharmacy. If that box is checked, users could be warned that the prices generated by the Plan Finder might be different from what is actually experienced if they do not use a preferred pharmacy. We also urge CMS to ensure that instructions on the Plan Finder make it very clear that selecting a pharmacy for the purposes of using the Plan Finder does not lock the beneficiary into using the chosen pharmacy.

Integration with ACOs and Other CMS Innovation Models

CMS is interested in Part D sponsors of stand-alone PDPs playing a greater role in managing the care of FFS beneficiaries and contributing to overall health outcomes. One strategy under consideration would be to enable business arrangements between the new Medicare Shared Savings Program ACOs or Pioneer ACOs and Part D sponsors for improved coordination of pharmacy care but flags the program integrity, legal and policy issues involved. CMS requests comments on potential strategies for better coordination, and specific activities to accomplish that. CMS is also interested in feedback from Part D sponsors on innovative payment or service delivery models that promote improved medication adherence.

AARP COMMENTS: AARP strongly supports this concept. There is much symmetry between many ACO quality measures and ensuring the value of prescription drugs, but the current Medicare system works against reinforcing such symmetry and shared accountability. Through innovation pilots, ACOs should employ on-site clinical pharmacists to perform MTM services for eligible PDP enrollees; both ACOs and PDPs should share in savings from avoided prescription drug-related medical visits, emergency room visits and hospitalizations. Further, extension of the invitation for a comprehensive medication review (one MTM component) could be issued by the prescriber, instead of by the PDP: this could help to generate buy-in by prescribers for pharmacist-recommended medication changes made as part of MTM; and buy-in by patients to participate in the comprehensive medication review. CMS Innovation Advisors should actively recruit Part D plans to develop additional pilots with community retail pharmacists, managed care pharmacists, and for ACOs unable to integrate pharmacists into their practice setting.

However, AARP urges CMS to exercise caution moving forward. Part D expenses are not included in either the base or performance calculations for ACOs or Pioneer ACOs, which could encourage ACO providers to shift to pharmaceuticals in lieu of other care and services. CMS must ensure that the incentives for both ACOs and Part D sponsors are properly aligned and balanced.

Low Enrollment Plans (Stand-alone PDPs only)

CMS continues to be concerned about the viability of Part D plans with low number of enrollees and urges sponsors to consider withdrawing or consolidating any stand-alone plan with less than 1,000 enrollees on a voluntary basis. In April 2012, CMS will provide plans with less than 1,000 enrollees a reminder of available options.

AARP COMMENTS: AARP strongly encourages CMS to review plan Part D plan enrollment trends and to work towards a policy of not contracting with plans that fail to enroll at least 1,000 beneficiaries in two or more consecutive years.

CMS should also consider utilizing performance ratings in its decisions whether to renew low-enrollment plans, and ensure that enrollees in non-renewed low enrollment plans experience a smooth transition to alternative plans.

Benefit Thresholds

As noted in the Advance Notice, beneficiary coinsurance under the defined standard benefit within the coverage gap for CY 2013 is 70% for generic drugs and 97.5% for brand drugs. These amounts result from the phased reduction in the coverage gap provided by the Affordable Care Act.

CMS advises that it will only approve a bid submitted by a Part D sponsor if its plan benefit package or plan cost structure is substantially different from those of other plan offerings by the sponsor in the service area with respect to key characteristics such as premiums, cost-sharing formulary structure or benefits offered. Moreover, tiered cost sharing for non-defined standards benefit designs may not exceed levels annually determined by CMS to be discriminatory. The methodology that CMS uses to establish the parameters for CY 2012 is the same as for last year although CMS indicates that it may change it next year. Specific proposed CY 2013 threshold values are presented (Table VI-7). For gap coverage, the proposed maximum beneficiary coinsurance is 59% for preferred generic and non-preferred generic tiers and 69% for preferred and non-preferred brand drugs.

AARP COMMENT: AARP appreciates the ongoing efforts by CMS to scrutinize plan offerings by Part D sponsors for meaningful differences using objective and transparent criteria. As we noted in last year's comment letter, we remain concerned about the high level of beneficiary cost-sharing that is permitted for Part D plans offering gap coverage. However, we commend CMS for ensuring that the additional gap coverage offered by enhanced plans reflects meaningful enhancements over the standard prescription drug benefit; such assessments will become increasingly important as the coverage gap discounts continue to grow. Enrollees should not pay a higher premium for "enhanced" coverage that is not meaningfully different from what they would get in a basic plan.

AARP supports the use of an out-of-pocket costs (OOPC) or market basket approach to set thresholds for increases in cost-sharing and premiums and deny Part D plan bids with significant increases in either. This methodology provides a more informative cost perspective and is consistent with CMS's efforts to ensure that Part D plans demonstrate meaningful differences.

Plan Finder

CMS advises that it is developing enhancements for the Medicare Plan Finder. These enhancements will permit a sponsor to submit and display floor and ceiling pricing and also to submit and display pricing for 30, 60, and 90-day fills at both retail and mail order pharmacies. The floor pricing enhancement will be launched during the spring 2012 refresh. The ceiling price and quantity fill enhancements are expected in September 2012 for the CY 2013 MPF display.

AARP COMMENT: AARP supports CMS in its efforts to improve the pricing information available on the Medicare Plan Finder website. The three enhancements that CMS described should help beneficiaries obtain a more realistic estimate of their drug costs for a particular Part D plan. Moreover, the enhancement relating to drug fill quantities should help reduce confusion for beneficiaries who traditionally use mail order for their prescription drugs and provide a clearer picture ofcost differences, if any, between retail and mail order.

Online Enrollment through the Medicare Plan Finder (MPF)

For 2011, CMS developed a low-performing plan icon for the Medicare Plan Finder to help beneficiaries more easily identify plans that have received ratings of fewer than 3 stars for three consecutive years. For the 2012 OEP, CMS added explicit messaging to warn beneficiaries about enrolling in low performing plans. For 2013 OEP, CMS proposes to disable the MPF online enrollment function for new enrollees so that they cannot enroll on line in drug plans with the low-performing plan icon. Beneficiaries who still want to enroll in such a plan or who may need to in order to get the benefits and services they require (for example, in geographical areas with limited plans) will be warned, via explanatory messaging of the plan's poorly rated performance, and directed to contact the plan directly to enroll.

AARP COMMENT: We strongly support measures improving the ability of beneficiaries to make informed decisions about selecting health and prescription drug plans. The five star rating system provides an important cue to beneficiaries about how a Part D plan is performing on key outcomes, process and satisfaction measures, and we support the steps taken in 2011 and 2012. However, we are concerned that the proposed step for 2013 could negatively impact access for beneficiaries who have no choice but to enroll in a plan with fewer than 3 stars. Rather than disable online enrollment entirely, CMS should consider providing explanatory messaging and requiring the enrollee to acknowledge they are aware of the plan's poor performance before being able to move forward in the process.

Misuse of Five-Star Rating

CMS plans to scrutinize Parts C and D marketing materials to ensure sponsors are not misleading beneficiaries by implying in their marketing materials that they received a higher overall plan rating than is actually the case. Sponsors must only use plans' overall ratings in marketing materials so as to not mislead Medicare beneficiaries into enrolling in plans based on inaccurate information.

AARP COMMENT: AARP strongly supports the efforts by CMS to review plan marketing materials and to eliminate misleading marketing. CMS should prioritize reviewing the marketing materials of lower performing plans. Plans found not to be in compliance should be publicly identified; repeat instances of misleading marketing of plan performance should lead to penalties and/or plan termination.

Complaint Tracking Module (CTM) Monitoring

For CY2013, CMS is planning to update the Evidence of Coverage (EOC) notice sent annually to beneficiaries to include two additional links: the online complaint form and a beneficiary complaint resolution web survey. CMS reports that it implemented an electronic Medicare online complaint form which went live December 2010 and has been placed on the www.medicare.gov homepage; Medicare Plan Finder homepage; and Medicare Ombudsman homepage. MAOs and PDP sponsors also are required to prominently display a link to this electronic complaint form on their websites. CMS also believes that information captured from surveys asking beneficiaries about how well their complaint was handled and satisfaction with the outcome is an important patient protection. It notes that in 2012, a web based version of this survey will be made available via a link on the same page as the online complaint form.

AARP COMMENT: AARP strongly support CMS's efforts to collect complaint resolution information and suggests that CMS consider making the results of this survey publicly available so beneficiaries can incorporate this information into their plan enrollment decisions. Similarly, the data gathered should be considered for use in CMS's formal evaluations of Part D plan performance.

Medication Therapy Management Program (MTMP)

CMS provides clarifications to specific questions that it has received from plans about comprehensive medication review (CMR). In addition, CMS notes that it is considering including the Pharmacy Quality Alliance (PQA) MTM measure (percentage of beneficiaries in MTM program who received a CMR) on the 2013 display page. Sponsors are encouraged to leverage effective MTM to improve Plan Ratings and to use the monthly reports on the Part D Patient Safety Analysis website to help identify beneficiaries for whom targeted MTM interventions may be beneficial and achieve better outcomes.

Information about MTM programs was included in the 2012 *Medicare & You Handbook* and beneficiaries can view MTM program eligibility information via a link on the MPR. CMS is exploring other ways to integrate this information into the MPF. Also, starting in 2013, sponsors will be required to have a link on their website to MTM program information. Plan sponsors are encouraged to post a blank Personal Medication List from the CMR standardized format on their website or provide information to beneficiaries about how to obtain a blank copy.

Although CMS expected more beneficiaries would be eligible for MTMP following changes to the eligibility criteria in 2010, the rate has remained at 10% to 13% since 2006. Plan sponsors may be restricting their MTM eligibility criteria to limit the number and percent of beneficiaries who qualify for these programs and would be required to be offered CMRs. CMS is conducting an analysis to examine the combinations of chronic diseases plan sponsors require for targeted enrollment and prevalence in the Medicare population. It is also evaluating the extent to which MTM programs target populations with medication therapy issues and the programs' impact on clinical outcomes and costs. Changes to these eligibility requirements are being examined, and sponsors should optimize their targeting of beneficiaries who are most likely to benefit from access to MTM services.

For 2013, CMS is designating two additional core chronic diseases for targeting: Alzheimer's disease and End-Stage Renal Disease (ESRD) requiring dialysis. These chronic diseases were targeted by over 10% of MTM programs in 2011. It is also adding Atrial Fibrillation to the list of non-core chronic diseases in the selection table in the HPMS MTM Program Submission Module. In addition, beginning in 2013, sponsors are expected to target at least five out of the nine core chronic conditions, instead of the current criteria of targeting at least four out of seven core chronic diseases.

AARP COMMENTS: AARP commends the continued focus by CMS on this issue and its efforts to carefully examine MTM requirements to determine whether changes are merited to better target MTM services to populations that would otherwise receive a disparate level of care. As we have noted in previous comment letters, we agree with CMS that the current use of MTM services by Part D plan sponsors is less than ideal and encourage the agency to take more aggressive steps to improve upon MTM services in ways that do not impede appropriate access for plan enrollees. CMS should consider developing concomitant opportunities for Part D sponsors to be rewarded for providing – and Part D eligible enrollees rewarded for participating in – more robust MTM services that help to generate savings across the Medicare system in terms of avoidable medication-related problems.

We support the proposed change beginning 2013 to require sponsors to target at least five out of the nine core chronic conditions, instead of the current criteria of at least four out of seven core chronic diseases. We also encourage CMS to provide additional information on MTM in *Medicare and You*, as well as a blank Personal Medication List, as this is something that would be beneficial to all Medicare beneficiaries.

AARP also urges CMS to utilize enrollment weighted data in its annual MTM Fact Sheet, which would provide a more accurate portrayal of how MTM programs are being implemented. CMS should also consider piloting the use of total Medicare costs in the prior year as MTM targeting criteria independent of “core” chronic diseases.

Improving Drug Utilization Review Controls in Part D

CMS is concerned about overutilization of certain prescription drugs, including certain opioids, which can result from a variety of reasons including multiple providers who do not know or have access to information on what other providers are prescribing for a given patient. Drug plans do have the capability, however, to track such information and should be doing a better job of preventing such behavior via utilization review controls. CMS describes different levels of review and tools that Part D plans can and should employ to improve drug safety and patient outcomes. In addition, CMS identifies improvements to formulary management processes that should be employed by Part D sponsors to comply with program drug utilization management requirements. Implementation of the different levels of review by a sponsor will be considered a minimum standard of compliance with respect to overutilization of opioids beginning CY 2013. Should these levels of review not prove effective at establishing medical necessity and result in plan implementation of beneficiary-level point of service edits, which CMS believes would be a rare instance, CMS is also proposing that sponsors share beneficiary-level data about overutilization when a beneficiary changes plans.

AARP COMMENTS: AARP supports CMS's efforts to encourage Part D plans to provide for robust utilization review as long as they do not impede appropriate timely access and fully comply with the Part D exceptions and appeals process.

AARP also urges CMS to consider providing prescribers with feedback about over- (and under-) utilization. Prescriber-level interventions such as continuing education on controlled substances should be addressed more globally, not just through plan-sponsored point-of-sale interventions.

In addition, CMS notes that plans' clinical staff should, "when warranted, intervene with prescribers, pharmacies and beneficiaries to ascertain medical necessity." CMS should ensure that such interventions (especially at the prescriber level) are de-identified, collected, and analyzed nationally, and shared publicly so that the prescribing community can benefit from timely opportunities to improve rational prescribing.

Thank you for the opportunity to provide comments on the 2012 Advance Notice and draft 2012 Call Letter for the Medicare Advantage (MA) and Part D Prescription Drug programs. If you have any questions, please contact Leah Cohen Hirsch on our Government Relations staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs