Abrazo Advantage Health Plan

An Affiliate of Abrazo Health Care

#18

August 14, 2006

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development—A
Attention: Melissa Musotto, Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

To whom it may concern:

Thank you for the opportunity to comment on the proposed 2007 Part D reporting requirements. Abrazo Advantage Health Plan (AAHP) offers the following comments in response to these proposed requirements:

- **Section XII: Transition: Data Elements B and C**
  AAHP has previously requested its pharmacy benefit manager (PBM) to build a tracking code and reporting mechanism for this purpose. However, AAHP has concerns about the CMS expectations of health plans to confirm that its network of retail pharmacies (i) track, (ii) monitor and (iii) report medications provided during a member's transition period. AAHP recommends that CMS clarify its expectations of health plans whenever retail pharmacies fail to accurately and completely track and report this data.

- **Section IX / Appeals: Data Elements Q and R**
  AAHP recommends that these data elements be struck from the final reporting requirements. CMS and its contracted agents already monitor compliance with the response timelines for standard and expedited re-determinations. In addition, these elements are labor intensive to generate and, as such, too onerous when compared against their relative analytic value.

If you have any questions about these comments, please feel free to contact me at 602-824-3870.

Thank you.

Sincerely,

Philip Nieri
Director of Government Program Compliance
Abrazo Advantage Health Plan (H5985)
pnieri@abrazohealth.com

NACDS
NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

#19

August 15, 2006

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-A,
Attention: Melissa Musotto, Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Subject: Draft Reporting Requirements for Part D Plans

To Whom it May Concern:

The National Association of Chain Drug Stores (NACDS) is writing to comment on the draft reporting requirements for Part D plans for 2007.

Medication Therapy Management: Plans should be required to report the numbers and types of providers under their plans that are offering MTM services, and the scope and number of services offered by each provider type. For example, plans should report whether MTM services are offered and provided by call centers, face to face interaction with community retail pharmacies, or other providers. Plans should also report the amount of payments being made for each service being provided by category of service and provider.

Transition: NACDS requests that the plans report on a specific separate contact number that pharmacies can use to obtain additional information from the plan about their transition policies.

Reporting PBM: We urge that CMS require that Part D plans also report the PBM that serves as the prescription claims processor for the Part D plan, whether a PDP or MA-PD. Knowing the underlying PBM that is processing the claims is critical for CMS as it is for pharmacies. This information should be reported to CMS. Several different plans may be using the same PBMs to process their claims. However, the PBMs are sending a single remittance statement to pharmacies and are generally not reporting the specific plan for which they are paying a claim. This makes it difficult if not impossible for retail pharmacies to engage in a claims reconciliation process.

We appreciate your consideration of this request and ask that you contact us for further information. Thank you.

Sincerely,

John M. Coster

John M. Coster, Ph.D., R.Ph.
Vice President, Policy and Programs

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#20

August 11, 2006

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – A
Attention: Melissa Musotto, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Musotto:

Please find attached Independent Health's comments/recommendations regarding 2007 Part D Reporting Requirements. These comments/recommendations are in reference to a memo from Gary Bailey, dated June 21, 2006, entitled *60 Day Public Comment Period for 2007 Part D Reporting Requirements*.

Independent Health is represented by contract H3344, H3362, and H9519. Please feel free to contact me with any questions regarding these attached comments/recommendations. Thank you for your time and consideration.

Sincerely,

Jeremy M. Laubacker
Project Manager – Medicare

Independent Health, H3344, H3362, H9519
Medicare Part D Reporting Requirements
Contract Year 2007
Comments & Recommendations

Section III – Medication Therapy Management Programs

Element J.

We recommend that an algorithm be used to ensure consistency between plans when calculating the average number of covered Part D 30-day equivalent prescriptions per beneficiary per month.

The algorithm we suggest is as follows:

Sum of Day Supply divided by 30 (this is the average number of 30 day equivalent prescriptions). This could then be divided by total member months in the reporting period.

Section X – Call Center Measures: Beneficiary Service Line and Pharmacy Support Line

Element B., D., F., H., J., L.

We have an inability to currently report Pharmacy Support Line measures at a specific plan or contract level. Drilling down to this detailed level would involve extreme hardship/investment because of the technology necessary to track pharmacy calls at a plan and/or contact level.

Element I., J.

We currently do not have the technology in place to track the number of calls (both for beneficiary and pharmacy lines) completed with the issue resolved and not requiring a call back. This would require investment in an additional module and presents a challenge for 1/1/2007.

Section XIII – Pharmaceutical Manufacturer Access/Performance Rebates Received by LTC Pharmacies

We believe obtaining and collecting this data from LTC pharmacies would be over burdensome on plans. It would likely involve updating legal contracts. CMS would be better served by collecting this data directly from the LTC pharmacies or the manufacturers.

Linda Potts
Compliance Manager

#21

CIGNA

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August 11, 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development—A
Attention: Melissa Musotto, Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Musotto,

RE: CIGNA HealthCare (S5617 & H0354) - Comments for 2007 Part D Reporting Requirements

CIGNA HealthCare Senior Care Medicare Part D appreciates the opportunity to comment on the draft 2007 Reporting Requirements issued by the Centers for Medicare & Medicaid Services on June 21, 2006. Below are our comments for your consideration.

Section III. Medication Therapy Management Programs

E. The number of beneficiaries who discontinued participation from the MTMP due to death at any time during the specified time period above. This should be a numeric field.

F. The number of beneficiaries who discontinued participation from the MTMP due to disenrollment from the Plan at any time during the specified time period above. This should be a numeric field.

Currently, CIGNA does not know the reasons behind plan disenrollment, whether it was caused by death or normal plan switch activity. Unless this information is provided through CMS eligibility file feed, it would be difficult to make such distinction between the two metrics outlined above.

Section III. Medication Therapy Management Programs

G. The number of beneficiaries who discontinued participation from the MTMP at their request at any time during the specified time period above. This should be a numeric field.

H. The number of beneficiaries who declined to participate in the MTMP during the specified time period above. This should be a numeric field.

CIGNA is seeking clarification on the difference between metric G and H, we allow members to opt out of the program at any point and opt out decision sometimes does not get communicated to us until later after they have participated in the program for a few months. How do we differentiate this scenario from the ones measured under G, where member requested discontinuation of the program?

Section IX. Appeals

*Q. Average number of hours for the Plan to complete **standard** redeterminations (excluding those redeterminations forwarded to the IRE due to failure to meet the 7 day timeframe). This should be a numeric field.*

CIGNA is seeking clarification regarding capturing data in hours vs days. CIGNA believes this standard should be measured in days instead of hours.

Section IX. Appeals

*R. Average number of hours for the Plan to complete **expedited** redeterminations (excluding those redeterminations forwarded to the IRE due to failure to meet the 72 hour timeframe). This should be a numeric field.*

CIGNA is seeking clarification regarding capturing data in hours vs days. CIGNA believes this standard should be measured in days instead of hours.

Section X. - Call Center Measures: Beneficiary Service line and Pharmacy Support line

I. *For the time period specified above, provide the number of calls to the Beneficiary Service line completed with issue resolved and not requiring a call back. This should be a numeric field.*

CIGNA's PDP contract currently does not have the ability to track "open calls" or "closed calls" and this would require extensive system programming to capture. CIGNA would request this reporting requirement be removed until such time CMS notifies Sponsors in advance of the proposed change to allow time for system upgrades.

Please let me know if you have any questions or if you need further clarification. You can reach me at 615.792.1313.

Sincerely,

Linda Potts

Linda Potts
Medicare Part D Compliance Manager

Cc: Ben Robinson
David Hu
Yi Zheng

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#22

HUMANA.
Guidance when you need it most

August 15, 2006

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – A
Attention: Melissa Musotto, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Humana's Comments in Response to the 60 Day Public Comment Period for 2007 Part D Reporting Requirements

Dear Ms. Musotto:

Please find enclosed Humana's comments regarding the draft 2007 Part D Reporting Requirements.

General comments

- Will HPMS be upgraded to allow for an automated or upload process for all reports? Entering the data contract by contract leaves room for human error. Will there be a red line from the 2006 Reporting Requirements?

Section III. Medication Therapy Management Programs

- Options for Data Element "A" do not fit well with Humana's method for enrollment. As it stands now, all contracts under Humana would list "other" as the method for enrollment.

Section V Grievances

- For "P", is CMS wanting the actual hours in minutes and seconds (mm:ss)?

Section VII Transition

- Does "B" & "C" relate to transition of care drugs only or all drugs?

Section IX Appeals

- For "Q" & "R", does CMS want the actual hours in minutes and seconds (mm:ss)?

Section X Call Center Measures: Beneficiary Service and Pharmacy Support Lines

- For "I" & "J", need clarification from CMS on whether they want excluded those calls where the members call back a second time regarding the same issue, whether the customer service rep calls the member back with a resolution, or both.

- For "K" & "L", does CMS want calls tracked from the welcome message through the CSR completion or IVR to CSR completion? Does CMS want actual talk time? Is a regular hold time included in the calculation?

Section XIII Pharmaceutical Rebates LTC Pharmacies

- This report is burdensome. LTC pharmacies earn rebates based on purchases, not claims. They don't purchase on Line of business, but instead purchase based on need. Claims will not be useful. This report doesn't appear to show how the rebates impacted access. Not reported on non-formulary drugs.

Final Comments:

- Will there be a third comments period? If so, when will we get a final draft?

Please do not hesitate to contact me should you have any questions. I may be reached at 502/580-3161.

Sincerely,

Sally A. Scott
Director, Medicare Part D & Pharmacy Compliance
Humana Inc.