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NSCLC

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Melissa Musotto
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
FAX: (410) 786–0262

RE: Comments on 2007 Part D Reporting Requirements

Dear Ms. Musotto:

On behalf of the National Senior Citizens Law Center and the Center for Medicare Advocacy, Inc. and our clients we appreciate the opportunity to submit the attached comments on the Medicare Part D Reporting Requirements for Contract Year 2007.

If you have any questions about these comments, please contact me or Georgia Burke, at 510-663-1055, ext. 303 or gburke@nsclc.org.

Sincerely,

Kevin Prindiville
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Comments on 2007 Draft Reporting Requirements Guidelines Submitted by the National Senior Citizens Law Center (NSCLC) and the Center For Medicare Advocacy, Inc. (CMA)

Organization Type: Non-profit advocacy on behalf of low-income seniors and individuals with disabilities (NSCLC), Advocacy on behalf of Medicare beneficiaries (CMA)

Page	Description of Issue or Problem	Suggested Revisions or Comments
Entire document	The introduction to the guidelines contains little information about how this information will be used by CMS or whether it will be shared with the public.	We encourage CMS to make this information widely available to the public. In a market driven system like Part D, consumers must have access to as much information as possible in order to make informed decisions about their health care. Allowing consumers to see the information reported by the plans per these requirements would present consumers with an invaluable tool as they make their plan selection. In order to provide consumers with the maximum benefit of this information, the reports themselves should be made directly available to the public as well as a summary prepared by CMS which consolidates the information into a concise, consumer friendly report.
3	We applaud the agency's decision to require plans to report specific, separate information on LIS beneficiaries. The LIS beneficiary population is a particularly vulnerable population. These individuals are the sickest and poorest of all Medicare beneficiaries. There are also facing added complications via	We encourage CMS to require plans to provide breakdowns of LIS beneficiary specific information wherever possible.

	the transition from Medicaid drug benefits to Medicare drug benefits. It is extremely helpful to have specific information on and for these individuals.	
	The current Enrollment/Disenrollment reporting requirements do not contain a field for discerning the number of individuals who enrolled in the plan during the reporting period. Plans are required to report the total number of non-LIS and LIS enrollees respectively and the total number of disenrollments among non-LIS and LIS beneficiaries respectively, but this information alone will not provide the number of individuals newly enrolled in the plan. Plans are required to report the total number of new enrollees in the Transition section (Section VII), but it make sense to also have that information reported here, with the other enrollment numbers.	Add a field for number of non-LIS beneficiaries who were newly enrolled in the plan during the reporting period and a field for number of LIS beneficiaries who were newly enrolled in the plan during the reporting period
	The data plans provide on enrollment does not distinguish LIS beneficiaries who affirmatively enrolled in the plan from those who were automatically enrolled or had their enrollment facilitated.	Add a new field for number of LIS beneficiaries whose original enrollment was automatic/facilitated. Add a new field for number of LIS beneficiaries who were automatically/facilitated enrolled into the plan during the quarter.
	The data does not include information about individuals who used or tried to use a Special Enrollment Period to enroll or disenroll from the plan during the reporting period.	Add new fields reporting the number of beneficiaries who request a SEP for each of the allowable reasons, the number for whom the SEP was granted, the length of time it took to verify the SEP and the length of time it took to process the SEP request.
6	There is no requirement to report the actual amount paid in claims.	Add a field for amount spent on generic claims.

7-8	The introduction to this section provides a number of examples of grievances. One of the biggest issues that advocates have seen has to do with enrollment and disenrollment problems. Another big issue is recognition of LIS eligibility. These issues should be included in the examples provided.	In the introduction, insert enrollment/disenrollment problems and problems with recognition of LIS eligibility into the list of potential grievance topics.
	Due to the particularly vulnerability of the LIS population, we urge the agency to require plans to provide LIS specific information whenever possible. Providing LIS specific information here would allow LIS beneficiaries to see whether some plans have been more difficult for LIS beneficiaries to navigate than others.	Add a new field for each current measure which gives specific LIS beneficiary information for the measure.
9	Plans should take extraordinary measures to ensure that members of the P&T committees are free of bias and conflict. This should be reflected in the information plans provide on committee members.	Change "Indicate if..." to "Indicate that..." Require plans to report any past or present, real or potential conflicts.
10	Due to the particular vulnerability of the LIS population, we urge the agency to require plans to provide LIS specific information whenever possible. Transition policy execution is particularly important for new dual eligibles who are transitioning from Medicaid drug coverage to Medicare Part D coverage. It is important for them to see how their population is handled by each plan.	Add a new field for each measure which provides data on the transition policy for LIS eligible individuals specifically. I.e. total number of newly enrolled LIS beneficiaries, total number of transition prescriptions provided to LIS beneficiaries, number of LIS enrollees receiving more or one transition prescription.
11	The use of the term "non-formulary exceptions" is confusing and inconsistent with the Prescription Drug Plan Manual, Ch. 18. The Manual uses the term "formulary exception." This guidance should be consistent with other the guidance that have been issued by the agency.	Change "non-formulary exceptions" to "formulary exceptions" in the heading and the first sentence of the text.

	Due to the particular vulnerability of the LIS population, we again urge the agency to require plans to provide LIS specific information whenever possible.	Add a new field for each category of prior authorization/exception transaction (step edits, PAs, exceptions, etc.) which provides data on claims for LIS eligible individuals specifically.
	There are two timeframes – standard and expedited – for processing of coverage determinations (PAs, exceptions, etc.). Plans should breakdown the information regarding each type of determination by the requested timeframe in order to demonstrate any differences between the two systems. Such a breakdown would also be consistent with the requirements in Section IX, Appeals.	Currently there is one field for each type of coverage determination request (prior authorization, exception for non-formulary medication, tiering exception) and one field for each type of coverage determination approval. This should be broken down into two request fields (standard and expedited) and two approval fields (standard and expedited).
	While the plan is required to report a variety of pharmacy transaction rejections, nowhere is the plan required to report all pharmacy transactions rejected.	Add a new field for total number of pharmacy transactions rejected during the reporting period.
	In section IX, plans are required to provide detailed information about the number, type and result of appeals. Similarly detailed information should be provided for the exceptions or coverage determination level.	Add new fields providing information on coverage determination requests including: - Total number of standard coverage determination requests - Total number of expedited coverage determination requests - Total number of expedited coverage determination requests granted expedited status. - Total number of standard/expedited coverage determination requests withdrawn respectively - Total number of standard/expedited coverage determination requests approved in favor of the enrollee respectively - Total number of standard/expedited coverage

		determination requests partially in favor of the enrollee respectively - Total number of standard/expedited coverage determination requests denied respectively - Total number of standard/expedited coverage determination requests denied due to insufficient evidence of medical necessity Each of these fields should contain a separate LIS breakdown as well.
	We are pleased with the Agency's decision to require plans to report the average number of hours for redetermination decisions in Section IX, Appeals. This information should also be provided for initial exception/coverage determination requests. These fields should also clarify that the plans must report total hours, not business hours.	Add a new field for the average number of hours (including non-business hours) for the plan to complete standard coverage determinations. Add a new field for the average number of hours (including non-business hours) for the plan to complete expedited coverage determinations.
12	Once again, we encourage CMS to require plans to provide LIS specific information in this section	Add a field for each measure that provides LIS enrollee specific information.
	We applaud the agency's decision to breakout expedited status approvals for the redetermination stage of appeals. This information should be provided for every stage of appeal, but currently is not. Plans are not required to indicate the total number of IRE requests or the number of IRE requests that were expedited.	Add a field for total number of appeals submitted for IRE reconsideration. Add a field for the number of IRE reconsideration requests that requested expedited status. Add a field for the number of IRE reconsideration requests that were granted expedited status.
	The IRE is not the end of the appeal process. The same information that is provided for lower appeals (number filed,	Add fields indicating the number of appeals that were pursued to the level of an ALJ, the MAC and federal

	outcomes) should be provided for all level of appeals, including appeals that advance to an ALJ, the MAC and federal court.	court respectively. Also add fields indicating the number of decisions affirming and denying, respectively, the original coverage determination at each level.
	The Medicare regulations allow for final determinations made by the plan, the IRE, an ALJ or the MAC to be reopened in certain circumstances. Data on reopenings should be included with other information about appeals.	Add a field for the total number of reopened cases. Include fields indicating how many cases were reopened at each level, i.e the plan, the IRE, an ALJ and the MAC respectively. Fields should also be added which indicate the number of reopened cases that approved and denied the original coverage determination respectively.
14	Many Part D eligible individuals speak a language other than English. It is important for these individuals to see which plans are capable and have a proven record of being able to assist them in their native language. The call center measures could provide some of this information.	Add a break out of each measure in this section which specifies the number of calls in each measure that were non-English speakers. In the alternative… Add a new field for the total number of calls to the Beneficiary Service line which were handled in a language other than English. Add a new field for the total number of calls to the Pharmacy support line which were handled in a language other than English.
15	Enrollees should be made aware of the percentage of overpayments made by a plan that are eventually recouped from the enrollee. Enrollees will want to stay away from plans that frequently make these types overpayments.	Add a field for the total overpayment dollars recouped by the Plan that were recouped from plan enrollees.

16	There is currently no field providing a total amount of dollars saved/reimbursed from rebates and other discounts.	Add a field for total value added in dollars from all rebates and discounts combined.
18	There is currently no field providing a total amount of dollars received from manufacture access/performance rebates.	Add a field for total value added in dollars from all manufacture access/performance rebates.
19	We urge the agency, once again, to provide LIS specific information whenever possible.	Add a LIS beneficiary specific field for each measure, including the new measures suggested below.
	It would be helpful to have information about the total number of prescriptions the plan provided per enrollee.	Add a field for total number of medications provided during the period.
	It would be helpful to have information about the total amount of money spent by the plan per enrollee.	Add a field for total dollars spent per enrollee during the period.