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MEDICARE DRUG BENEFIT AND C & D DATA GROUP

TO: Office of Management and Budget

FROM: Lori Robinson, Director
Division of Plan Data

DATE: December 18, 2009

SUBJECT: Response to CMS-R-262 Comments

CMS appreciates the comments provided on the Paperwork Reduction Act (PRA) package CMS-R-262, *Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)*. Our responses to the comments submitted are below.

Formulary Comments

1. Formulary – Step Therapy

The recently proposed CY2011 PBP/Formulary List of Changes contains several proposed changes that would potentially benefit from a more complete description or explanation. Specifically, the appropriate use of the ST_Change_Criteria_Indicator field in the Step Therapy File; and the Step_Therapy_Group_Desc and Step_Therapy_Step_Value fields in the OTC File is unclear.

The document attached to these comments includes a more complete request for clarification and examples of the possible interpretations as the proposed changes are currently written.

It is requested that these ambiguities be clarified in the final guidance when it is released.

CMS RESPONSE: These changes will be discussed in formulary submission training and included in the Formulary Submission Module and Reports Technical Manual. CMS provides an online training module for the formulary as well as a user group call with the plan industry to address questions or concerns. These forums are made accessible to any interested party (inside or outside of the plan industry) and generally run about an hour long each.

Plan Benefit Package (PBP) Comments

2. PBP – Section B – 18 a (Hearing Services)

The PBP tool only allows plans to enter a total maximum plan benefit coverage amount for hearing aids - all types. The tool does not allow plans to enter a maximum plan benefit coverage amount for each hearing aid per ear. If plans have a maximum plan benefit coverage amount per ear for hearing aids - all types, they should be able to indicate this in the PBP data entry so this level of detail can be communicated to the member in the SB. Otherwise, the member may assume they're able to apply as much of the total maximum plan benefit coverage amount to a single hearing aid for one ear, which may not be true for all plans.

CMS RESPONSE: CMS had previously reviewed this request and determined that we would not make the change to the PBP software. CMS determined that the vast majority of plans do not offer a maximum coverage amount on a hearing aid benefit per each ear. Rather, the norm is for plans to apply a maximum coverage amount on the hearing aid benefit overall, which is the data entry structure provided by the PBP. Moreover, CMS concluded that adding this nuance to the already complex hearing aid benefit description could lead to more beneficiary confusion. The plan can still enter this aspect of their benefit design into the PBP free-form note fields and include the information on their marketing materials

3. PBP – Section C – Visitor/Travel (V/T)
The CY211 PBP List of Changes describes a new edit rule for the Section C Visitor/Travel benefit wherein if any categories are chosen as a Visitor/Travel benefit, at least one Visitor/Travel Group from that section needs to be chosen. Once a Visitor/Travel Group has been designated, the plan must then select the service categories that are included for the Group and indicate the minimum and maximum coinsurance/copayment if cost sharing varies from what was entered in Section B. If the cost sharing for service categories included for the Group varies, do you suggest we give a range from the minimum to the maximum copayment/coinsurance for the Group?

CMS RESPONSE: CMS does not have a preference. Each plan must determine their approach based on their internal business decisions regarding benefit design. Plans can enter the benefit however they choose as long as their entry shows the true cost share values. For example, a plan can enter a benefit as $0 or 0% because they share the same meaning.

Organizations have the ability to create up to 15 different groups in Section C of the PBP software. Organizations may choose to create one group for all of the V/T services and provide a minimum to maximum range of cost sharing. Organizations may also choose to divide up the service categories in up to 15 groups with distinct cost sharing in each group.

4. PBP – Optional Supplemental Premium
The Optional Supplemental Premium field is disabled for all plan types except 1876 Cost Plans. As a result, the SB no longer populates the additional monthly premium for our optional supplemental benefits. From the beneficiary's perspective, it is important to call

out the additional monthly premium amount for the optional supplemental benefits, in addition to the monthly plan premium and the monthly Part B premium.

CMS RESPONSE: Plans are required to manually enter their optional supplemental premium in their local SB, per guidance issued by CMS. By complying with CMS instructions, plans will ensure that the SB provides beneficiaries with a complete picture of the available benefits.

CMS made this change (i.e., removing the duplicate premium data collection from the PBP and only collecting premium data in the BPT) in an effort to avoid potentially misleading information. Prior to the change, plans were required to enter this data field into both the BPT and the PBP. The presence of this dual data entry created a risk where the two fields would not match, so CMS decided to collect all premium information in the BPT.

The SB optional supplemental premium is collected in the MA Bid Pricing Tool (BPT), and it would be duplicative to capture the optional supplemental premium in the PBP as well. The HPMS SB reports display the optional supplemental premium, and this information is also displayed on Medicare Options Compare (MOC). Organizations are to include the optional supplemental premium in their SB to give beneficiaries a complete picture of the benefits available.

5. PBP – Coverage Gap Thresholds

The coverage gap thresholds as established in the 2010 Call Letter and are continuing in plan year 2011 are confusing to the member. Many plans have a few generic drugs on the specialty tier. This is due to the fact that the negotiated prices of these few drugs exceed $600 per month. However, the tiers state that all drugs = 100% and many drugs = 65% - 99%. A plan that includes a minimal amount of generic drugs on the specialty tier is then forced to report its generic gap coverage as "Many". This is confusing to the member who is looking for generic coverage in the gap. In addition, this could influence plans to reduce the number of generic drugs covered in the gap. The tiers should be revised to enable a plan with a minimal amount of generic drugs (15 or less) that are not covered to be labeled as "Most" or CMS should exclude drugs on the specialty tier from the calculation.

CMS RESPONSE: The CY 2010 Call Letter provides instructions on gap coverage labels. The brand and generic gap coverage labels are derived separately and for the entire benefit package not at the formulary tier level. If a minimal amount of generic drugs (≤15) are included in gap coverage, the gap label for generics would be “No Gap Coverage”.

6. PBP – Section Rx

The Out-of-network cost sharing structure questions on the PBP tend to cause confusion for many plans. Definitions for each option should be supplied in order to ensure each plan is interpreting the questions in the same way. On the 3rd option - In Network

Copay / Coinsurance with Limited Days Supply, clarification is requested on the Limited Days Supply part of the definition.

CMS RESPONSE: The out-of-network cost sharing requirements are described in Chapter 5 of the Medicare Prescription Drug Benefit Manual, which is posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage.

7. PBP – Bid Documentation

In the bid documentation, provide clearer instructions around excluded drugs and how they should be entered in the PBP (e.g., included in an existing tier vs. separate tier with examples for each scenario).

CMS RESPONSE: Excluded drugs are submitted as a supplemental file through the Formulary Submission Module. Part D plans have the option of including excluded drugs on an existing tier or a separate tier. The PBP software is designed to accommodate both options.

Please refer to page 15 of the following file: Appendix_C_PDP_2011_screenshots_sec_Rx_121709_final.pdf. This information is also outlined in the formulary submission user manual. Plans must make an internal business decision regarding how they choose to structure their Medicare Part D benefit. Organizations may create an excluded - drug only tier or combine excluded drugs with other Part D drugs. CMS will accept both structures.

8. PBP – Plan Copy Feature

During the programming of the Plan Benefit Package (PBP) last year CMS was working on programming that would copy PBP information from the previous year into the current PBP. Throughout the alpha and beta testing the functionality was working. When the final software was released, there was a copy function however it was not as complete as we had seen in testing. We would like to see a complete copy function for PBP data from previous year into the current year.

CMS RESPONSE: CMS provides as a year-to-year copy functionality that is as complete as is technically feasible. If there are significant changes to the PBP software from year-to-year, the database tables are modified (e.g., new fields, deleted fields, new business logic) making it impossible to completely copy the entire PBP from year-to-year.

9. BPT – Historical Data

The BPT's request historical non-benefit expense information as well as the non-benefit expense for the projection period. Our plan recently went through a CMS financial audit in which the auditor was trying to map the experience period expense to the projected period expense. The projected period non-benefit expenses are built on the expenses we project for the projection period and it is not realistic to bridge from expenses two years ago to the projection period. We do not have any problem submitting the historical and

projection period expenses, however question whether the historical information is useful or if it should be eliminated from the BPT.

CMS RESPONSE: The historical information is useful to CMS during bid review and bid audit.

10. HPMS – General: Include the plan name, region name and region code any time the Contract and Plan ID are listed (e.g., final premium data).

CMS RESPONSE: CMS will investigate the suggested change for the 2012 development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

11. HPMS – Bid Reports: Create a Part D Benefit Bid Report that compares across Contracts and/or PBPs.

CMS RESPONSE: CMS will investigate the suggested change for the 2011 development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

13. HPMS – Bid Submission: Provide non-owners with a read-only option for the Plan-Specific Information page (currently, you must own the Plan to access and view this page).

CMS RESPONSE: CMS will investigate the suggested change for the 2012 development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of

making the change, considering where the software development effort sits in the system development lifecycle at that time.

14. HPMS – Bid Validations: Create the following bid validations between the PBP and formulary file submission: number of tiers, drug types.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

15. HPMS – Bid Reports: Ensure that the PBP SB reports mirror the HPMS SB reports.

CMS RESPONSE: CMS provides guidance to organizations that indicates organizations should update their local SB to match the SB report that generates in HPMS. The HPMS SB report contains information that is NOT entered in the PBP software and cannot be entered in the PBP software because the data is calculated at a later date (e.g., Plan Premium), is entered in another tool (e.g., the Optional Supplemental Premium), or is not known until a later date (e.g., Part B premium). Organizations must update their local SBs to mirror the HPMS SB report.

16. HPMS – Bid Submission: Enhance the Plan Crosswalk functionality to allow contract-to-contract crosswalking.

CMS RESPONSE: CMS is releasing guidance regarding the plan crosswalk in the spring of 2010 and this issue will be addressed at that time.

Summary of Benefit Comments

1. SB Section Rx: The basic alternative Part D benefit we file in the PBP as a default for SNP members who may lose their LIS eligibility no longer translates into the SB. The SB now reflects LIS cost sharing only. Why was this change made? The SB should reflect the cost sharing as reflected in the PBP. While the vast majority of SNP members are LIS eligible, there may be instances where SNP members lose their LIS eligibility due to unforeseen reasons; therefore, the non-LIS cost sharing that is filed in the PBP should be reflected in the SB.

CMS RESPONSE: If an individual is LIS eligible, they are typically eligible for the entire year. It is rare that someone loses LIS eligibility in the middle of the plan year. Beneficiaries who do lose their LIS eligibility should be disenrolled from SNP plans.

These members must be enrolled in regular MA and PD plans. Only members that are eligible for LIS cost sharing should be enrolled in these SNP plans, so the sentences are correct as designed based on the population that is allowed to be enrolled.

2. SB-Optional Supplemental Package: In the PBP, when the plan selects a combination of preventive dental services that are included in a single cost per office visit and then indicates the copayment amount for the office visit, one of the SB sentences under the Optional Supplemental Package section for Dental Services "up to 1 oral exam(s) every six months" is displaced. See example below.

In-Network

up to 1 oral exam(s) every six
months (this sentence should be should come after, not before the language '$30 copay for an office visit that includes')
$30 copay for an office visit
that includes:
- up to 1 cleaning(s) every six
months
- up to 1 fluoride treatment(s)
every six months
- up to 1 dental x-ray(s) every
six months

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

3. SB – Optional Supplemental Package: In the PBP, when the plan selects a combination of enhanced benefits that fall under the Optional Supplemental eyewear benefit, the SB sentence that describes the eyewear limit is reflected in the middle of the benefit description. See example below:

In-Network

$0 copay for contacts

$0 copay for lenses

$150 limit for eye wear every two years (Why is this sentence reflected in the middle of the benefit description? We recommend placing it at the end of this section.)

$0 copay for glasses

$0 copay for frames

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

4. SB – Optional Supplemental Package: In Section D of the PBP, the plan is able to select the benefit service categories that are offered as optional supplemental benefits; however, not all of the benefit service categories translate over to the Optional Supplemental Package section of the PBP. The plan recommends revising the SB to call out all optional supplemental benefits being offered under the Optional Supplemental Package section of the PBP.

CMS RESPONSE: The purpose of the Summary of Benefits (SB) is to highlight select benefits offered by the plan. The SB is not meant to be an all-inclusive document describing the benefits. The Evidence of Coverage (EOC) is the marketing document that is meant to fully describe all benefits being offered by a plan, and the optional supplemental benefits should be explained in their entirety in the EOC.

5. SB – Optional Supplemental Package: The plan offers an Optional Supplemental benefit package with preventive and comprehensive dental services up to a specified annual maximum plan benefit coverage amount (i.e. $750). The PBP tool does not give plans the flexibility to indicate whether the entire maximum plan benefit coverage amount will apply to either preventive or comprehensive services, or a combination of both. This past PBP season, the plan addressed this limitation by splitting the maximum plan benefit coverage amount into two separate amounts for preventive and comprehensive dental services ($250 for preventive, $500 for comprehensive). This description of the benefit is not entirely accurate, as the description suggests that a member can only apply $250 toward preventive and $500 toward comprehensive, as opposed to their true benefit, which is that they have $750 that can be applied however they choose between preventive and comprehensive services. The plan suggests the PBP tool include a new data entry variable in which plans can indicate whether the entire maximum plan benefit coverage amount will apply to either preventive or comprehensive services, or a combination of both.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

6. SB – General The SB that generates from the PBP does not match the SB that appears on HPMS in the Summary of Benefits. This creates problems when creating SBs and submitting them to CMS for review.

CMS RESPONSE: CMS provides guidance to organizations that indicates organizations should update their local SB to match the SB report that generates in HPMS. The HPMS SB report contains information that is NOT entered in the PBP software and cannot be entered in the PBP software because the data is calculated at a later date (e.g., Plan Premium), is entered in another tool (e.g., the Optional Supplemental Premium), or is not known until a later date (e.g., Part B premium). Organizations must update their local SBs to mirror the HPMS SB report.

7. SB-Intro: This comment pertains to the following sentence in the second new paragraph under the header 'What Are My Protections in this Plan?': "You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function". We recommend revising the sentence to "You may ask us for an expedited (fast) organization determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function." This new paragraph is about "organization determination", not coverage determinations", which is described in the subsequent paragraph below.

Additionally, information about expedited requests that is included in this new paragraph about "organization determinations," is not included in the paragraph below on coverage determinations. Expedited requests information should be added to the coverage determinations paragraph for consistency.

CMS RESPONSE: CMS has concluded that adding the word "organization" concerns style rather than a substantive change. Consequently, we are not making the requested change.

As to the second point, CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors

such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

8. SB – Intro: On the last page of the SB where the plan's toll free numbers are listed, in instances where the phone number for the Medicare Advantage Program and Medicare Part D Prescription Drug Program are the same, we recommend collapsing the two sentences into one to avoid redundancy.

Also, all phone numbers should list TTY/TDD numbers in any event.

CMS RESPONSE: CMS will consider the suggested change of combining the phone numbers for the 2012 PBP development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time. However, CMS currently allows organizations to combine customer service telephone numbers when they are the same (please see CY 2010 Summary of Benefits Global Hard Copy Changes, July 21, 2009).

CMS currently displays all TTY/TDD numbers in the Summary of Benefits Introduction.

9. SB – Section 1 – Premium and Other Important Information: This comment pertains to the following sentence under the "General" header: "$___ monthly plan premium in addition to your monthly Medicare Part B premium." Some beneficiaries also pay a Part A premium as well. Suggest revising the language to the following to make it more generic to fit all situations: "$__ monthly plan premium in addition to your monthly Medicare premiums".

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of

making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

10. SB – Section 1 – Premium and Other Important Information: Under the "In-Network" header, new SB language has been added that reads "There is no limit on cost sharing for the following services", and then lists all "Medicare Services" that are excluded from the out-of-pocket limit. It is true that there is no limit to the cost sharing for the excluded Medicare Services; however, the text does not clearly communicate that the amount the member is paying for the excluded Medicare services will not accrue to the out-of-pocket limit. For example, if a member spends $3,350 on excluded services, they have not reached the out-of-pocket limit; therefore they must continue to pay cost sharing for services that do apply towards the out-of-pocket limit. We recommend revising the sentence to the following: "The following services do not apply toward the annual out-of-pocket limit".

Additionally, we recommend revising the sentence "This limit includes only Medicare-covered services" to "This limit includes Medicare services". Plans may offer supplemental coverage for Medicare Services above and beyond what is covered under Original Medicare, and cost sharing for the supplemental coverage may also apply towards the annual out-of-pocket limit. The statement "This limit includes only Medicare-covered services" implies the member's cost sharing for Medicare services offered by the plan which are above and beyond what is offered under Original Medicare would not apply towards the annual out-of-pocket limit. This may not be true for all plans.

Additionally, we recommend moving the text "This limit includes only Medicare-covered services" so that it comes directly after the text "$XXX out-of-pocket limit".

CMS RESPONSE: CMS has concluded that the requested change concerns style rather than a substantive change. Consequently, we are not making the requested change.

11. SB – Section 29 – Prescription Drugs: On the Alternative-Deductible screen in the PBP tool, plans are able to choose one of three options to indicate their Out-of-Network cost sharing structure for the plan. The three options are: 1) In-Network Copay/Coinsurance (No Differential), 2) In-Network Copay/Coinsurance plus a differential between the OON billed and the In-Network Allowable, and 3) In-Network Copay/Coinsurance with Limited Days Supply.

Regardless of the option selected for the Out-of-Network cost sharing, the following SB sentence appears under Out-of-Network Initial Coverage: "You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,700". If the member had to pay the difference between the OON billed charge and the In-Network allowable, this sentence would be misleading. Recommend creating a unique sentence in the SB for each OON option defined in the tool.

The recommended SB change would also apply to the following sentence under Out-of-Network Gap Coverage: "You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following." The recommended change would also apply to the following sentence under Out-of-Network Catastrophic Coverage: "After your yearly out-of-pocket drug costs reach $4,350, you will be reimbursed out-of-network up to the full cost of the drug minus the following…"

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

12. SB – Section 29 – Prescription Drugs: Under the In-Network Coverage Gap section, it is not clear that the member will be responsible for paying 100% of the cost for Brand and Specialty drugs. The text currently reads "For all other covered drugs, after your total yearly drug costs reach $2,700, you pay 100% until your yearly out-of-pocket drug costs reach $4,350. Under the Out-of-network Coverage Gap section, Brand and Specialty are broken into distinct sections, and each paragraph gives a more thorough description of what the member is responsible for paying for Brand and Specialty drugs. Please consider revising the text under the In-Network Coverage Gap section so that Brand and Specialty are broken into distinct sections.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

13. SB – Section 29 – Prescription Drugs: Under the header "Drugs Covered Under Medicare Part D - General", request to revise the SB sentence "If you request a tier exception in this plan, you will be paying…" to "If you request a formulary exception in this plan, you will be paying…." Our understanding is the intent of the new Exceptions Tier question in Section Rx of the PBP is to identify the single cost share tier that applies

for drugs approved through the plan's formulary exceptions process. If this is the case, the SB language should state "formulary exceptions" rather than "tier exceptions".

CMS RESPONSE: This change was made for the final version of the 2010 SB and will be carried forward to CY 2011.

14. SB – Section 30 – Dental Services: Recommend revising the language "However, this plan covers preventive dental benefits for an extra cost…" to "However, this plan offers coverage of preventive dental benefits at an extra cost…." To avoid misleading beneficiaries, "cover" should not be used distinctively unless the plan is making a claim that something is in fact being covered.

CMS RESPONSE: CMS has concluded that the requested change to replace 'cover' with 'offers coverage' concerns style rather than a substantive change. Consequently, we are not making the requested change.

15. SB – Section 32 – Vision Services: Under In-Network Vision Services, the Plan suggests reinstating the description of the maximum plan benefit coverage amount for the mandatory supplemental eyewear benefit from Section B-17b PBP. Previously, the sentence in the SB read "$XXX limit for eye wear every two years". In addition to reinstating the maximum plan benefit coverage sentence, the plan recommends moving the description of the maximum plan benefit coverage amount after the text "up to 1 pair(s) of glasses every two years". This way it is clear to the member that the maximum plan benefit coverage amount applies to 1 pair of glasses covered every two years.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

16. SB – Intro : Page 2 of SB text - request to revise statement under header "WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK? to the following: "If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care)." Neither "Plan Name" nor the Original Medicare Plan will pay for these services.

CMS RESPONSE: CMS believes that adding the emergency care language to this sentence is not necessary. Emergency care is described in SB Section 15 (Emergency Care).

17. SB – Intro: Page 3 of SB text under header "WHAT ARE MY PROTECTIONS IN THIS PLAN?"-
For the sentence "You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost", plan requests making language "or believe you should get a non-preferred drug at a lower out-of-pocket cost" variable so it only prints for plans with preferred and non-preferred cost sharing.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

18. SB Intro: Page 3 of SB text - Is the language under header "WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?" needed in a Part D plan SB? If yes, the list should be revised to agree with the model EOC list BUT no brand names should be specified, (i.e., Epogen) since not all plans cover these types of drugs.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

19. SB – Section 1 – Premium and Other Important Information: The SB is given to prospects. Prospects may qualify for extra help and the premium stated in the SB is not the premiums these members will pay. Suggest revising the text to either allow plans to state what folks with LIS will pay or add a statement like so: "Different premiums apply for people who qualify for extra help."

CMS RESPONSE: CMS has taken much time to identify those areas that need to be modified for LIS and those beneficiaries who qualify for Medicaid. It was determined by CMS that the premium should display as is for Dual Eligible SNPs.

20. SB – Section 1- Premium and Other Important Information: This comment applies to SNP Plans only - The plan recommends you reconsider the placement for the following statement in the SB: "*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility."
First, it is placed under the plan's column when in fact it applies to the Original Medicare column too. So it should be a footnote or repeated in the Original Medicare column. Secondly, in the plan's column Medicaid eligibility doesn't affect any cost sharing. The only thing that affects cost sharing is LIS status and is limited to premiums and drug cost sharing. So all the asterisks in the plan column except in #1 and #29 should be deleted.

CMS RESPONSE: CMS purposefully put the sentence" All cost sharing in this summary of benefits is based on your level of Medicaid eligibility" at the top of the Summary of Benefits in the Plan column. A similar note is included in the Original Medicare column which states "The Medicare cost sharing amount may vary based on your level of Medicaid eligibility." Medicaid eligibility absolutely impacts the cost sharing in the summary of benefits, as Medicaid may pay for certain supplemental benefits that Medicare does not. CMS has taken must time to identify those area that need the asterisk, and we will continue to modify this as needed.

21. SB – Section 4 – Inpatient/Mental Health Care: Why is the following language under the plan column when the plan does not cover more than 190 days?: "Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days."

Also, why isn't the language "190 day lifetime limit in a Psychiatric hospital" included under the plan column instead of the Original Medicare column?

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

22. SB – Section 5 – SNF: Plan recommends adding "per benefit period" to the SB benefit description so that it reads:

Days 1 - 20 per benefit period: $0 copay per day

Days 21 - 100 per benefit period: $100 copay per day

We have had issues with members who think that when they are readmitted during the same benefit period that the clock starts over. For example, admitted on Jan-1 released on Jan-25; readmitted on Feb-5 - now member thinks it is no charge for another 20 days.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

23. SB – Section 7 – Hospice: Under SB #7 Hospice, we recommend that the language "You must get care from a Medicare-covered hospice" be removed from the Original Medicare column. Part B Only members must use network hospice – not Medicare-certified hospice. Please consider adding the statement "You must get care from a network hospice" under plan column for Part B only members.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

24. SB – Section 16 – Urgently Needed Care: Currently, In-Area Urgent Care is captured under #8 Doctor Office Visits and Out-of-Area Urgent Care is captured under #16 Urgently Needed Care. The plan recommends including In-Area and Out-of-Area Urgent Care under the same section in the SB chart, preferably under #16.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes;

and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

25. SB – Section 3, 4, 5, 7: Comment specific to SB #3, #4, #5, and #7 for Part B Only Plans – Original Medicare column of SB should reflect "Not Covered" as these are Part A services not extended to Part B Only members by Medicare therefore listing Part A services days, deductibles, cost-shares, and/or limits is misleading – Part B Only members have no Part A coverage under Original Medicare.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

26. SB – Section 29 – Prescription Drugs: Under 'Out-of-Network Initial Coverage' and 'Out-of-Network Catastrophic Coverage'

Request to add "plan's" to the following sentence:

"You will be reimbursed up to the [plan's] full cost of the drug minus the following…."

CMS RESPONSE: CMS has concluded that the requested change concerns style rather than a substantive change. Consequently, we are not making the requested change.

27. SB – Section 2 – Doctor and Hospital Choice: The following sentence under Out-of-Network section has been removed: "Plan covers you when you travel in the U.S."

The Plan suggests reinstating visiting member language similar to what was included in the 2008 SB:

2008:
Out-of-Network
Unless otherwise noted, out-of-network Services are not covered.

Or, one alternative recommendation is to include the following language:

Out-of-Network
Plan covers certain care you when you travel in the U.S. Contact plan for details.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors

such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

28. – SB – Section 29 – Prescription Drugs In the Plan column, the sentence "Authorization rules may apply" is not included for Part B only plans. This language is included under #5 SNF for our A/B plans, and should also be included for our Part B only plans.

CMS RESPONSE: CMS will investigate the suggested change for the 2012 PBP software development cycle. When evaluating requested changes, CMS considers factors such as: whether the change is consistent with statute, regulation, and CMS administrative policy governing the Part C and Part D programs; whether the change will provide greater understanding to the beneficiary community or cause more confusion; whether the change will provide value to the plan industry at large; the impact of the change on the software and other related functionality and by-products; the cost of making the change; the priority of the change against all of the other proposed changes; and the risk of making the change, considering where the software development effort sits in the system development lifecycle at that time.

29. **SB – Section 29 – Prescription Drugs**:Request to replace "the" with "a Part D plan" in the text below. This is important information and should be clearly communicated so beneficiaries who enroll during open enrollment are not misled into assuming that the benefit renews when they enroll in a new plan.

Recommended revision:
Total yearly drug costs are the total drug cost paid by both you and a Part D plan.

CMS RESPONSE: CMS has concluded that the requested change concerns style rather than a substantive change. Consequently, we are not making the requested change. The sentence in question is generated in SB 29, the prescription drug SB section, and if the organization does not offer Part D drugs, the above sentence would not generate. Clarifying that the Part D benefit applies to a Part D plan is not necessary.

30. SB – Intro: Current SB Intro text is ambiguous. Suggest changing to read same as follows from the CMS Model EOC:

Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.

Or, at a minimum add “administered” and “homebound” concepts to text.

Suggested revision to SB Intro Language:
Osteoporosis Drugs: Injectable drugs for osteoporosis for certain homebound women with Medicare who cannot self-administer the drug.

CMS RESPONSE: The language that currently generates in the SB is “Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.” CMS has concluded that the requested change concerns style rather than a substantive change. Consequently, we are not making the requested change.

31. SB – Intro: Page 4 of SB Intro – The current SB Intro text for injectable drugs, “Injectable Drugs: Most injectable drugs administered incident to a physician’s service.” is inaccurate because it states the drugs are administered “incident to” a physician service. The Plan suggests using the 2009 CMS model EOC language as folllows:

Drugs that usually aren’t self-administered by the patient and are injected while you are getting physician services.

CMS RESPONSE: CMS has concluded that the requested change concerns style rather than a substantive change. Consequently, we are not making the requested change. Changing “incident” to “while you are getting” mean the same thing in the context of this sentence.

32. SB – Intro: Page 4 of SB Intro - Plan suggests replacing “provided” with “administered” to make it clear that the drug must be administered using DME.

Suggested Text:
Inhalation and infusion drugs provided through DME.

CMS RESPONSE: CMS RESPONSE: CMS has concluded that the requested change concerns style rather than a substantive change (changing “provided” to “administered”). Consequently, we are not making the requested change.

If you have any questions regarding our responses, please contact Sara Silver at Sara.Silver@cms.hhs.gov or 410-786-3330. Thank you.