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CENTERS FOR MEDICARE & MEDICAID SERVICES

TO: Office of Management and Budget

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SUBJECT: Response to CMS-R-262 and CMS-10142 Comments

CMS appreciates the comments provided on the Paperwork Reduction Act (PRA) packages CMS-R-262, *Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)* and CMS-10142, *CY 2012 Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP).* Our responses to the comments submitted are below.

Plan Benefit Package (PBP) Comments

1. PBP – Section B – 7c (Occupational Therapy Services)
By removing minimum and maximum cost share in the therapy section the plan will not be able to charge by place of service (for example office vs. outpatient hospital). We recommend that CMS reconsider this new rule and allow plans to range therapy services by place of service, as has been permitted in previous years.

CMS RESPONSE: CMS allows minimum and maximum data entry where CMS believes cost sharing may vary. It was determined that Occupational Therapy services should only include one value that could be charged.

We cannot accommodate this change for Contract Year (CY) 2012. CMS will consider this suggestion for a future release of the PBP software.

2. PBP – Section B-3 (Comprehensive Outpatient Rehabilitation Facility (CORF)
Appendix B indicates that Comprehensive Outpatient Rehabilitation Facility (CORF) has been deleted from the PBP entirely. Based on this, it is unclear whether CORFs should be considered to be under the therapy section or whether a different cost sharing is

allowed based on place of service. We recommend that CMS allow a CORF to take a different cost share than an office setting or outpatient facility.

CMS RESPONSE: CMS removed the CORF data entry from the PBP since each service covered under the CORF has its own data entry section within the PBP. The CORF data entry duplicated cost sharing that is collected in other parts of the PBP tool.

However, CMS will consider this change for a future release of the PBP software.

3. PBP – Section B – 14a (Medicare-covered Zero Cost-Sharing Preventive Services)
Appendix B includes a discussion of the attestation which states that there is no coinsurance, copayment, or deductible for the following In-Network Medicare-covered Preventive Services'. Based on this statement, it is unclear whether plans may apply a copayment when preventive services are billed with a non-routine service. We recommend that CMS open additional screens that would allow plans to check mark that an office visit may be billed in addition to a preventive screening, if additional services are provided on the same day.

CMS RESPONSE: An organization may bill for other non-routine services if they are received during the same visit as a Medicare-covered Preventive Service. The cost sharing for the other non-routine service should be entered in the applicable PBP data entry section, not with the Medicare-covered Preventive Services Section.

4. PBP – Hospice Consultations
The plan suggests that there be a place in the PBP that asks what the plan charges for Hospice Consultations.

CMS RESPONSE: CMS cannot accommodate this request for Contract Year (CY) 2012. CMS will consider this suggestion for a future release of the PBP software. Please note, however, that all Medicare-covered services received while a beneficiary is in hospice care are covered under Original Medicare, even if the beneficiary is enrolled in a Medicare Advantage Plan.

5. PBP – Throughout
Some benefits are included in EOC but are missing from PBP. We recommend that every service that is identified in the EOC on the left hand side of the benefits chart have a PBP entry associated with it so that the EOC language on the right hand side is clearer.

CMS RESPONSE: This request cannot be accommodated for Contract Year (CY) 2012. CMS will consider this suggestion for a future release of the PBP software.

Bid Pricing Tool (BPT) Comments

1. BPT – Part D – Worksheet 6a
In Worksheet 6A, the drugs are split into the following categories: Generic, Preferred Brand, Non-Preferred Brand, Specialty Generic, Specialty Brand. However, the rules

about member share / plan payment in the Gap are driven by Applicable vs Non-applicable classification. Generic drugs can be Applicable and non-Applicable and Brand drugs can be Applicable and non-Applicable. We would appreciate CMS's comments on this difference and also guidance on the expectations for the member share values to be populated on this page.

CMS RESPONSE: The categories on Worksheet 6A are consistent with Worksheet 6. CMS has addressed the issue raised in this comment in the "Advance Notice of Methodological Changes for Calendar Year (CY) 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter" released on February 18, 2011. Specifically, from pages 29-30:

"…pharmaceutical manufacturers generally provide an approximately 50% discount to non-low income subsidy eligible (non-LIS) beneficiaries receiving applicable (brand) drugs in the coverage gap phase of the Part D benefit."

"**In Worksheet 6A** of the Part D bids, "Gap Coverage", Part D sponsors will project the **brand** drug cost sharing amounts for 2012 for non-LIS beneficiaries in the coverage gap."

"This reduction in cost sharing begins in CY 2011 and continues through CY 2020, ultimately resulting in 75% cost sharing for applicable drugs, prior to the application of any manufacturer discounts, and 25% cost sharing for other covered Part D drugs (non-applicable drugs). **Applicable drugs are defined at section 1860D-14A(g)((2) of the statute and are generally brand covered Part D drugs that are either approved under a new drug application (NDA) under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (BLA). Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug (i.e. generic drugs)**."

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

If you have any questions regarding our responses to BPT comments, please contact Diane Spitalnic at Diane.Spitalnic@cms.hhs.gov or 410-786- 5745.

Thank you.