



December 12, 2011

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Attention: CMS-4157-P – Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Proposed Changes; Considering Changes to the Conditions of Participation for Long Term Care Facilities

Submitted electronically to <http://www.regulations.gov>

Dear Ms. Tavenner:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments on selected provisions of the October 11, 2011 proposed rule “Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Proposed Changes; Considering Changes to the Conditions of Participation for Long Term Care Facilities.”

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for more than 16 million Americans, predominantly in the individual and small and mid-sized group markets. ACHP members have a significant presence in the Medicare Advantage market and many also contract with their states to provide coverage to Medicaid beneficiaries. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP’s comments are shaped by our members’ long-standing leadership in Medicare Advantage since the beginning of the program and our commitment to Triple Aim goals: improved experience of care, improved population health and lowered costs. That commitment is reflected in the most recent health plan ratings: ACHP members are seven of the nine plans in the nation receiving the top, five-star rating for MA plans.

ACHP appreciates CMS’ work in developing the proposed rule for the Medicare Part C and Part D programs, and in particular in implementing the new statutory requirements. We offer comments in several areas, focusing in particular on issues on which CMS asks for comments or guidance.

MAKING HEALTH CARE BETTER

Clarifying Coverage of Durable Medical Equipment (§422.100; §422.111)

Under current rules, network-based health plans may limit access to Medicare-covered items and services via networks, including cost-sharing tiers for preferred DME, as long as those networks provide adequate access to services consistent with CMS standards.

ACHP supports CMS' proposal to clarify the rules to allow an MA plan to limit coverage of DME items and supplies to specific manufacturers or brands, subject to specific terms and conditions set out in the proposed rule. Several of our members already do so, for example, identifying a preferred brand of glucose monitors and test strips. They took this step in consultation with relevant physician specialists. The savings have allowed them to eliminate co-payments. When CMS develops the final rule, we ask for clarification about one of the terms in proposed §422.100(1)(2)(v), which treats denials of non-preferred DME as an organizational determination subject to an appeal under current §422.566. In particular, we seek guidance on what the criteria would be for making decisions on appeals, and suggest that key considerations should include access to the DME and medical necessity.

New Benefit Flexibility for Fully-Integrated Dual Eligible Special Needs Plans (FIDE SNPs) (§422.102)

CMS proposes to afford fully-integrated dual eligible Special Needs Plans (FIDE SNPs) additional flexibility related to design and offering of supplemental benefits, as part of a set of initiatives to make Medicare and Medicaid work together more effectively. ACHP is fully supportive of policy that will better serve the dual-eligible population, which includes the programs' most vulnerable beneficiaries and constitutes about one-fourth of program spending in both Medicare and Medicaid.

CMS specifically asks for comment on whether its proposal to allow additional benefit flexibility to FIDE SNPs should be extended to other SNPs, as a means to reduce unnecessary use and improve beneficiary outcomes in those plans. ACHP agrees that an extension to a broader range of SNPs would allow them to offer supplemental benefits such as assistive devices and community living supports. Those additional benefits would be valuable additions for all SNPs in meeting needs of beneficiaries to prevent health status decline and avoid unnecessary institutionalization. In addition, such an extension allows SNPs to meet the needs of members who do not live in an area served by FIDE SNPs.

Finally, we support CMS' proposal to review these supplemental benefits to assure that they are reasonably limited to medical or functional supports and services designed to improve care, and not merely marketing/enrollment incentives.

Application of the Medicare Hospital-Acquired Conditions and Present on Admission Indicator Policy to MA Organizations (§422.504)

CMS proposes to require MA organizations to stipulate in their contracts with hospitals that payment will not be made for hospital-acquired conditions and present on admission (POA) indicator policy effective January 1, 2013. This change would mirror existing policy regarding Medicare payment to hospitals in the Inpatient Prospective Payment System (IPPS). ACHP appreciates CMS' recognition that MA organizations may pay hospitals on a basis other than the IPPS system,

and desire to offer flexibility to MA organizations in implementing the methodologies within their contract structures for reporting and payment.

ACHP supports this general policy direction and wants to be sure that MA plans can fully implement the requirements in a manner consistent with CMS' objectives. Several of our members have emphasized the administrative complexities in building both the reporting and payment provisions into every hospital contract, including redesign of payment approaches (and sometimes redesign of several hospital payment approaches within the same MA plan). In addition, plans must incorporate this approach into MA plan bids. Especially with a final rule not yet in place, we believe that the January 1, 2013 effective date is not realistic for the careful implementation the provision deserves. We recommend that the effective date be moved to January 1, 2014.

The proposed requirement would not be workable in the case of MA plans with hospital contracts that are fully capitated or operate on a fixed budget in an integrated system. In these cases, we recommend that the reporting provisions should suffice, as the payment incentives are already in place. With a fixed capitated payment or budget, these entities already suffer the fiscal consequences of the extra costs of hospital-acquired conditions.

Establishment and Application of Daily Cost-Sharing Rate as Part of Drug Utilization Management and Fraud, Abuse and Waste Control Program (423.153)

CMS proposes to require that Medicare Part D sponsors provide their enrollees access to a daily prorated cost sharing rate for prescriptions dispensed by a network pharmacy for less than a 30-day supply. These prescriptions include an initial fill of a new medication, are intended to allow the enrollee to synchronize refill dates of multiple drugs, or are dispensed in accordance with existing regulations. The daily cost-sharing rate requirements would apply to both brand and generic drugs. CMS believes that if Part D enrollees and their prescribers had the option of fewer days' supply of initial fills of new prescriptions, without the disincentive of the enrollee having to pay a full month's (or longer) copayment or coinsurance, a significant portion of the current cost of discontinued medications could be avoided.

ACHP appreciates the rationale for making this policy change and supports the goal of reducing waste in the dispensing of prescription medications. However, our members have pointed out a number of difficult operational considerations – for example, how would dispensing fees be prorated? How would plan sponsors account for this policy in their annual bids? There are also potential implications that we suggest should be explored further: Clinically, dispensing trial supplies could negatively affect medication compliance if patients do not return to the pharmacy to fill the remainder of the prescription. For generic drugs, pro-rated cost-sharing amounts may be so low that it raises the question of whether generics should be exempt from the requirement. Because plan sponsors may need more than one year to resolve the operational issues, and because CMS may want to continue to consider the clinical and cost issues, we recommend that CMS move back the effective date from January 1, 2013 to a later year.

Independence of Long Term Care (LTC) Consultant Pharmacists (483.60)

CMS is considering requiring the independence of LTC consultant pharmacists from LTC pharmacies, drug manufacturers and distributors. Nursing homes also would be prohibited from

contracting for consultant pharmacists that have a relationship with the LTC pharmacy. Instead, they would hire the pharmacist directly or perhaps hire one via a professional organization of consulting pharmacists. This possible policy change is viewed by CMS as necessary to ensure that financial arrangements do not influence the consultant pharmacist's clinical decision. Comment is requested on the specific relationships that should be permitted and whether it would make sense to waive the independence requirement to permit alternative approaches.

ACHP appreciates the concerns raised by CMS about the potential for financial arrangements between LTC pharmacies and their consulting pharmacists to affect medication recommendations for Medicare beneficiaries who are nursing home residents. As CMS has noted, such conflicts of interest may lead to the overprescribing of medications, the prescribing of drugs that are inappropriate for LTC residents, or the use of unnecessary or inappropriate therapeutic substitution. Our member plans work hard to ensure the highest quality of care and take steps directly or through contracts with Pharmacy Benefit Managers (PBMs) to monitor prescription drug utilization to ensure against inappropriate prescribing. Thus we support CMS' objective of minimizing the potential conflicts of interest, and look forward to commenting on further rule-making in this area. One option to explore is how more transparency and clarity around costs might play a role in addressing this problem.

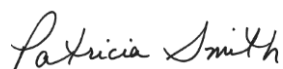
Medication Therapy Management Comprehensive Medication Reviews and Beneficiaries in LTC Settings (§423.153)

Current regulations reflect a concern that telehealth technologies for conducting comprehensive medication reviews (CMRs) may not be appropriate for all beneficiaries, including those with cognitive impairments residing in LTC facilities. Plan sponsors are exempt from having to offer interactive CMRs to targeted beneficiaries in LTC settings. However, the ACA amended the law to require that all beneficiaries targeted for medication therapy management review be offered an interactive comprehensive medication review (CMR), regardless of patient setting.

CMS proposes to revise the regulations to require sponsors to offer the annual CMR to targeted beneficiaries in an LTC facility. However, when the beneficiary cannot accept the offer to participate, the pharmacist or other qualified provider must perform the medication review without the beneficiary. ACHP supports this modification to the regulations and would appreciate guidance on the specific responsibilities of a plan sponsor in implementing this policy change. In particular, we suggest that the plan sponsor be permitted to look to the provider for the decision as to whether the patient can participate in the CMR.

Thank you for consideration of our comments. If there are questions or we can provide additional information, please contact Howard Shapiro, Director of Public Policy, at hshapiro@achp.org.

Sincerely,



Patricia Smith
President and CEO