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MEDICARE FACT SHEET

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CMS COMMITMENT TO CONTINUOUS QUALITY IMPROVEMENT DRIVES REQUIREMENTS AND EXPECTATIONS FOR 2007 PRESCRIPTION DRUG PLANS

BACKGROUND

The choices beneficiaries are making, the operational and systems improvements made thus far, and the Centers for Medicate & Medicaid Services' (CMS) commitment to continuous quality improvement in the Medicare prescription drug program have informed the instructions to and expectations of the prescription drug plans as the plans prepare their bids for 2007. Medicare Part D plans must build on the improved customer service, strengthened data exchange systems, and other operational enhancements they have made thus far.

The CMS goal is to ensure that the plans meet high standards of customer service and other key dimensions of performance. Additionally, because strong relationships with pharmacists and other health care providers are critical to the successful delivery of this benefit to Part D enrollees, CMS is requiring plans to continue to streamline their Part D operations to avoid unnecessary administrative burdens.

CMS's final evaluation of a prescription drug plan (PDP) sponsor's qualifications to participate in the Part D program during 2007 continues throughout 2006. CMS will continue routine monitoring, audits, and data review on the performance metrics being collected this year. If at any time a PDP sponsor is determined to be substantially out of compliance with Part D requirements and does not demonstrate that it has taken adequate steps to correct the problems, further CMS enforcement actions may include contract termination proceedings prior to the start of the 2007 contract year.

PROMOTING COMPETITION THAT PROVIDES BETTER BENEFITS AT A LOWER COST

As of mid-March, over 7.2 million people have, either on their own, with the help of family or friends, or with the assistance of one of the thousands of counselors and volunteers across the country, individually enrolled in Part D, and hundreds of thousands more beneficiaries are choosing drug coverage each week. Beneficiaries are choosing plans that best meet their needs, leading to coverage that serves them better and costs less for them and for taxpayers. Enrollment data reveal that the vast majority of beneficiaries are choosing plans that offer benefits other than the standard option as defined in the law. They are choosing plans that have low premiums, no

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deductibles, fixed copays, coverage in the gap or "donut hole." In fact, only 16 percent of PDP enrollees chose the standard, statutory option and only 5 percent of MA-PD enrollees chose the standard option. Beneficiaries are also often choosing plans with access to a broad range of drugs through very broad formularies.

CMS want to ensure that plan choices offered in 2007 clearly meet beneficiary needs, and enable beneficiaries to compare different kinds of plans and confidently choose the coverage that is best for them. CMS intends to negotiate with prescription drug plan sponsors to ensure that each bid submitted represents variation based on plan characteristics that will provide meaningful, clearly understandable and substantially significant options for beneficiaries. Key options where beneficiaries have different preferences include the option of a zero versus higher deductible, flat copays versus coinsurance for covered drugs, enhanced coverage in the coverage gap versus a more basic benefit, and broader versus more tightly managed access to particular drugs. CMS expects competition to move toward providing more support for beneficiary comparisons of plans in these key dimensions, along with premiums and drug costs. CMS expects that, for many sponsors, two plan choices will be sufficient unless the sponsor offers enhanced coverage.

BUILDING ON STEPS TO ENSURE HIGH-QUALITY SERVICE

CMS will review each PDP sponsor's compliance with all requirements of the program to determine whether contract renewal is warranted. While many plans are performing well or are achieving significant improvements in key areas of beneficiary service and support, CMS may consider non-renewal if there has been a substantial failure to comply with program requirements. As the drug benefit is just completing its third month, CMS will consider information being collected now and in the months ahead on plan performance. Special attention will be paid to key operational areas which impact customer satisfaction and successful delivery of the benefit, including effective data systems, customer and provider service, exceptions and appeals processes and pharmacy support.

Effective Data Systems. CMS expects sponsors to develop and maintain information systems that accurately process updated enrollment information at least weekly. CMS expects that successful plans will follow best practices for timely and accurate processing and verification of enrollment and copay information, particularly in the case of plans serving beneficiaries eligible for Medicare and Medicaid. System interaction metrics for PDP plan sponsors will be used in these ongoing monitoring efforts.

Effective Customer Service. Key dimensions of customer service include timely access for beneficiaries and their representatives, pharmacists, and other health professionals. CMS is conducting routine surveys to determine plan compliance with Part D standards concerning call abandonment rates and percentage of calls answered within 30 seconds. Plans will receive this analysis to inform their performance and compliance analysis, and information on the performance of plan service lines will be publicly available in the weeks ahead. Complaint rates related to customer service are also an important consideration for future participation by a plan.

Transition Guidance Compliance. CMS fully expects PDP sponsors to follow both agency transition guidance and their own approved transition processes. For example, all PDP sponsors must provide a temporary supply of non-formulary drugs for 30 days in the retail setting and 90 days in the long term care setting. In addition to providing the transition supply, PDP sponsors

must also inform their enrollees of the following key information: (1) the transition supply is temporary, (2) enrollees need to work with their plan and physician to switch to a therapeutically appropriate on-formulary drug, (3) they have a right to request a formulary exception if they or their physician believe a non-formulary drug is medically necessary, and (4) how to access the exceptions and appeals procedures. CMS is also monitoring complaints related to difficulties in completing the transition process.

Strengthen Relationships with Providers through Avoiding Excessive Burdens in the Exceptions and Appeals Process. Sponsors should develop a "one stop" shopping area on their website that provides ready access to all of the transition, prior authorization, exception and appeals information and forms that enrollees and their providers need. CMS will monitor provider wait times, compliance with exceptions and appeals time frames, and complaint rates to make certain that the results are satisfactory.

Strengthen Relationships with Pharmacists through Effective Pharmacy Support. PDP sponsors must comply with contractual agreements with their participating pharmacies. CMS has been and will continue to investigate and track pharmacists' complaints about plan compliance with their pharmacy contracts. PDP sponsors are also expected to implement best practices in pharmacy transactions, including the use of consistent transaction codes and secondary messages when a requested prescription fill is denied. Plans must comply with CMS guidance on cobranding, to ensure that beneficiaries receive accurate information about the broad range of pharmacies available to serve them.

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