



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

Part D Benefits Policy & Operations

Part 1

TODAY I'M GOING TO BE DISCUSSING
PART D BENEFIT POLICY

AND OPERATIONS.

THE AGENDA FOR TODAY INCLUDES

A BRIEF OVERVIEW
OF PART D POLICY.

I'LL HIGHLIGHT SOME PBP CHANGES

AS WELL AS SUPPLEMENTAL
FILE CHANGES.

I'LL REVIEW BID DESIGN

AND SUBMISSION REQUIREMENT
REMINDERS,

BENEFIT REVIEW UPDATES.

AND FINALLY ENDING WITH
SOME COMPLIANCE ISSUES.

ON FRIDAY APRIL 16th, CMS POSTED

THE 2011 PART D PLAN BENEFIT
PACKAGE SUBMISSION AND REVIEW

INSTRUCTIONS MEMORANDUM.

THIS MEMO ADDRESSES TWO RECENTLY
ENACTED PROVISIONS

UNDER THE AFFORDABLE CARE ACT,

TWO REGULATORY PROVISIONS

THAT DIRECTLY AFFECT 2011 BID
AND BENEFIT PACKAGE REVIEWS,

AND INCLUDES UPDATES
AND REMINDERS

ON BENEFIT PACKAGE DESIGN
AND SUBMISSION REQUIREMENTS.

MUCH OF TODAY'S PRESENTATION IS
DERIVED FROM THIS MEMO.

SO IF YOU HAVE NOT DOWNLOADED
IT ALREADY, I URGE YOU TO DO SO

AND READ IT CAREFULLY PRIOR
TO PREPARING AND SUBMITTING

YOUR BIDS.

STANDARD GUIDANCE REGARDING
CMS EXPECTATIONS AND ALLOWANCES

FOR BENEFIT PACKAGES AND
SUPPLEMENTAL FILE SUBMISSIONS

CAN BE FOUND IN CHAPTERS 5-7

OF THE PRESCRIPTION
DRUG BENEFIT MANUAL.

AND YOU CAN LOCATE
THESE DOCUMENTS

ON THE CMS WEBSITE
AT THE WEB LINK PROVIDED

ON THIS SLIDE.

THE KEY COMPONENTS
OF THE BENEFIT--

THE DEDUCTIBLE, ICL,
COVERAGE GAP,

OUT-OF-POCKET THRESHOLD,
AND THE CATASTROPHIC COVERAGE.

THE DEDUCTIBLE, ICL,
OUT-OF-POCKET THRESHOLD,

AND COST SHARING

IN THE CATASTROPHIC PHASE OF THE
BENEFIT ARE ADJUSTED ANNUALLY.

WITH THE EXCEPTION OF THE ICL,

ALL OF THESE PARAMETERS REMAIN
THE SAME FOR 2011.

THIS--JUST SHOWS A COPY OF OUR
STANDARD BENEFIT SLIDE.

I'M SURE MANY OF YOU HAVE SEEN
THIS SLIDE IN OTHER VERSIONS

FOR PREVIOUS YEARS.

AS I MENTIONED BEFORE,
THE ICL HAS CHANGED TO \$2,840.

BUT THE TROOP AND THE DEDUCTIBLE
REMAIN THE SAME.

ONE OTHER THING YOU MAY NOTICE
IS THAT UNDER THE HCERA--

THE HEALTH CARE AND EDUCATION
RECONCILIATION ACT OF 2010--

ADDITIONAL COVERAGE OF PART D
DRUGS WILL BE PHASED

INTO THE BENEFIT BETWEEN 2011
AND 2020

SUCH THAT BY 2020 THE STANDARD
BENEFIT WILL COVER

75% OF THE COST OF GENERIC DRUGS
IN THE GAP.

FOR 2011, THE PLAN'S PORTION
WILL COVER JUST 7% OF THE COST

OF GENERICS IN THE GAP.

THERE ARE 3 TYPES OF BASIC
PRESCRIPTION DRUG COVERAGE.

THERE'S THE DEFINED STANDARD,
THE ACTUARIALLY EQUIVALENT,

AND THE BASIC ALTERNATIVE.

ENHANCED ALTERNATIVE COVERAGE
PROVIDES MORE VALUE

THAN THE BASIC PLANS BY
PROVIDING SUPPLEMENTAL BENEFITS

IN ADDITION TO BASIC
PRESCRIPTION DRUG COVERAGE.

EXAMPLES OF THIS SUPPLEMENTAL
BENEFIT COULD BE

REDUCTION IN THE COST SHARING
IN THE COVERAGE GAP.

AND AS I MENTIONED FOR 2011,
ANY GAP COVERAGE THAT'S OFFERED

IS IN ADDITION TO THE STANDARD
7% COVERAGE

OF THE COST SHARE OF
GENERICS IN THE GAP.

SUPPLEMENTAL DRUG COVERAGE
IS ANOTHER EXAMPLE OF

A SUPPLEMENTAL BENEFIT.

AND THESE ARE PART D DRUGS.

THESE ARE DRUGS THAT WOULD
OTHERWISE BE COVERED

UNDER PART D BUT FOR THE FACT

THAT THEY'VE BEEN
EXPLICITLY EXCLUDED

FROM THE PART D BENEFIT.

AND YOU CAN FIND
MORE INFORMATION

ABOUT THESE BENEFIT TYPES
IN CHAPTER 5.

YESTERDAY, APRIL 19th, WAS
THE DEADLINE

FOR FORMULARY SUBMISSIONS FOR
2011.

ON MAY 14th, THE BID SUBMISSION
WINDOW OPENED.

AND ON JUNE 7th, THE WINDOW
CLOSES.

JUNE 7th IS ALSO THE DEADLINE
FOR CROSSWALKING YOUR PLANS

TO FORMULARIES.

PLEASE NOTE THIS BECAUSE THIS IS
A CHANGE FROM LAST YEAR.

JUNE 14th ARE WHEN THE
SUPPLEMENTAL FILE WINDOW OPENS.

AND JUNE 16th IS THE DEADLINE
FOR SUBMISSION

OF YOUR SUPPLEMENTAL FILES.

AND, FINALLY, OCTOBER 1st, IS
THE DEADLINE

FOR SUBMISSION FOR ANY PLAN
CORRECTION REQUESTS,

WHICH WE HOPE WE DO NOT RECEIVE
ANY OF.

THERE WERE A NUMBER OF PBP
CHANGES IN 2011.

I WILL HIGHLIGHT SOME OF
THE MORE IMPORTANT ONES

RELATED TO THE Rx SECTION
OF THIS TOOL.

CMS HAS HEARD FROM VARIOUS
PARTIES THAT

LARGE NUMBER OF DRUG TIERS
AND NON-STANDARDIZED LABELING

OF THOSE TIERS ARE CONFUSING
THE BENEFICIARIES

WHEN THEY'RE TRYING TO COMPARE
PLANS.

IN ORDER TO KEEP DRUG BENEFITS
MEANINGFUL TO BENEFICIARIES

WHILE ALLOWING SPONSORS ADEQUATE
FLEXIBILITY

IN THEIR BENEFIT DESIGN,

CMS HAS REVISED THE PBP
AND FORMULARY UPLOAD SOFTWARE

FOR CONTRACT 2011 TO ACCEPT
A MAXIMUM OF 6 TIERS.

THIS INCLUDES ANY EXCLUDED
PART D ONLY TIERS.

WHILE THE TOOL PERMITS A MAXIMUM
OF 6 TIERS, WE ENCOURAGE

SPONSORS TO CONSIDER SUBMITTING
BENEFIT DESIGNS

WITH FEWER FORMULARY TIERS
WHERE POSSIBLE, AS WE BELIEVE

FEWER TIERS WILL SIMPLIFY
BENEFICIARY COMPARISONS

ACROSS BENEFIT PACKAGES.

WE REMIND PLANS THAT THE NUMBER
OF TIERS IN THE PBP MUST MATCH

THE NUMBER OF TIERS IN
THE FORMULARY EXCEPT WHERE YOU

ARE OFFERING
AN EXCLUDED DRUG ONLY TIER,

IN WHICH CASE YOU WOULD HAVE
ONE ADDITIONAL TIER

OR IN THE EVENT THAT YOU ARE
SUBMITTING

A DEFINED STANDARD PLAN.

AND NEW FOR 2011 THERE WILL BE
NO ENTRY OF THE TIER NUMBER

FOR DEFINED STANDARD PLANS.

THIS IS JUST A SCREEN SHOT OF
WHERE YOU WOULD ENTER

THE NUMBER OF TIERS IN
THE Rx SECTION OF THE PBP TOOL.

AND, AGAIN, IF YOU SELECT
THE DEFINED STANDARD BENEFIT,

THE "INDICATE NUMBER OF TIERS"
FIELD WILL BE GRAYED OUT,

OR DISABLED.

TO IMPROVE THE CLARITY AND
CONSISTENCY OF DRUG TIER LABEL

DESCRIPTIONS FOR BENEFICIARIES,
WE HAVE UPDATED

THE 2011 PBP SOFTWARE TO DISPLAY

A MENU OF STANDARDIZED DRUG
LABELS.

THESE ARE DERIVED IN PART

FROM SOME OF THE MORE COMMON
DRUG LABELS USED FOR 2010

BY PART D SPONSORS.

THE PBP TOOL NO LONGER ALLOWS
FREE-TEXT ENTRY

OF TIER TYPE LABELS.

FOR 2011, THE PLANS WILL CHOOSE
FROM A LIST OF LABEL OPTIONS.

THE ALLOWABLE OPTIONS WILL BE
BASED ON THE SELECTIONS MADE

ON THE TIER TYPE SCREEN,
WHICH INCLUDE

THE TYPE OF DRUGS THAT ARE
GOING TO BE ON THE TIER,

WHETHER OR NOT YOU'RE GOING TO
INCLUDE EXCLUDED DRUGS

OR IT'S A MIX OF EXCLUDED DRUG
OR PART D,

WHETHER OR NOT THE TIER IS
THE SPECIALTY TIER.

AND I WANTED TO NOTE THAT
FOR 2011, THE SPECIALTY TIER

CAN ONLY BE LABELED AS
SPECIALTY TIER DRUGS.

AND ANY PLANS THAT HAVE
AN EXCLUDED DRUG ONLY TIER,

YOU MUST INCLUDE AN OPTION THAT
HAS "SUPPLEMENTAL" IN THE NAME.

THESE STANDARDIZED LABELS
WILL BE POPULATED

IN THE SUMMARY OF BENEFITS.

AGAIN, THIS IS A SCREEN SHOT
OF THE TIER TYPE PAGE

IN THE PBP TOOL,

WHERE, AGAIN, ALL OF
THE INFORMATION THAT IS SELECTED

ON THE LEFT-HAND SIDE OF
THE SCREEN WILL FACTOR IN

TO THE LABELS THAT WILL BE
ALLOWED TO VALIDATE

ON EXITING THE TOOL.

AND THIS SCREEN SHOWS YOU
THE AVAILABLE TIER LABELS

FOR YOUR 2011 TIERS.

AND WHILE IT SHOWS EVERY SINGLE
POSSIBLE LABEL THAT YOU

COULD PICK DEPENDING ON YOUR
ANSWERS, AGAIN, ONLY THOSE

THAT ARE APPROPRIATE FOR
THE ANSWERS THAT YOU'VE PROVIDED

ON THE PREVIOUS SCREEN WILL BE
ALLOWED TO VALIDATE

UPON EXITING.

AS MENTIONED EARLIER,
PLANS OFFERING

AN ENHANCED ALTERNATIVE BENEFIT
MAY ELECT TO OFFER GAP COVERAGE

ON DRUGS THEY ARE ALSO PROVIDING

COVERAGE FOR PRE-ICL.

AS DESCRIBED IN THE 2010
CALL LETTER,

CMS IMPLEMENTED THE USE

OF STANDARDIZED GAP COVERAGE
LEVEL DESCRIPTIONS FOR EACH PLAN

OFFERING GAP COVERAGE.

AS IN 2010, CMS WILL QUANTIFY
EACH PLAN'S GAP COVERAGE

BASED ON THE PERCENTAGE OF
FORMULARY DRUGS COVERED

THROUGH THE GAP AND THEN WILL
ASSIGN APPROPRIATE DESCRIPTIONS.

THESE DESCRIPTIONS WILL AFFECT
ADDITIONAL DRUG COVERAGE

IN ADDITION TO THE MANDATED
7% COVERAGE

OF GENERIC DRUG COSTS IN
THE GAP FOR 2011.

WE NOTE THAT SUPPLEMENTAL DRUGS
WILL NOT BE FACTORED IN

TO THIS DETERMINATION.

AND YOU CAN REFER TO THE CALL
LETTER FOR 2010

ON, SORT OF, MORE DESCRIPTION
OF HOW IT IS WE DERIVE

THESE CALCULATIONS--
VIEW THE PERCENTAGE

OF FORMULARY GENERICS
OR FORMULARY BRANDS.

THE SAME THRESHOLDS AND
DESCRIPTIONS FOR 2010

WILL BE USED FOR 2011.

AND, AGAIN, THERE ARE SEPARATE
CALCULATIONS

FOR YOUR FORMULARY BRANDS
AND YOUR FORMULARY GENERICS.

THE DESCRIPTIONS
AND THE THRESHOLDS ARE

THE SAME, HOWEVER.

THERE'S ALL, MANY, SOME, FEW,
AND NONE.

AND YOU CAN SEE HERE
THE THRESHOLDS

FOR EACH OF THE DESCRIPTIONS.

FOR 2011, SPONSORS WILL
NO LONGER INDICATE

THEIR LEVEL OF GAP COVERAGE
IN THE PBP.

THIS WAS A CHANGE FOR 2010
THAT THEY ENABLED A SCREEN

WHERE SPONSORS COULD ENTER
WHAT THEY THOUGHT

THEIR GAP COVERAGE LEVEL
WAS GOING TO BE.

AND WE HAVE REMOVED THIS
FROM THE PBP FOR 2011.

AGAIN, CMS WILL BE CALCULATING
THIS AS WE DID LAST YEAR.

BUT WE WILL BE PROVIDING
AN HPMS REPORT

TO REVIEW THE COVERAGE LEVEL
DESCRIPTIONS THAT WE HAVE

ASSIGNED TO YOUR PLAN.

AND THIS WILL BE AVAILABLE IN
JULY OR AUGUST

FOR THOSE PLANS THAT HAVE AN
APPROVED FORMULARY AT THAT TIME.

AND JUST AS A REMINDER, THESE
ADDITIONAL GAP COVERAGE LEVEL

DESCRIPTIONS WILL BE DISPLAYED
IN A SUMMARY OF BENEFITS

AND SHOULD BE USED

IN ANY OTHER MARKETING
OR PLAN DISSEMINATED MATERIALS.

Part 2

ACCORDING TO THE PART D
REGULATIONS,

EACH MA ORGANIZATION OFFERING
PART D BENEFITS MUST OFFER

REQUIRED PRESCRIPTION DRUG
COVERAGE

THROUGHOUT ITS SERVICE AREA.

THIS MEANS COVERAGE OF PART D
DRUGS THAT CONSIST

OF EITHER BASIC PRESCRIPTION
DRUG COVERAGE

OR ENHANCED ALTERNATIVE COVERAGE
PROVIDED THERE IS

NO MA MONTHLY SUPPLEMENTAL
BENEFICIARY PREMIUM APPLIED

UNDER THE PLAN.

IN ORDER TO HELP ENSURE THAT
THIS REQUIREMENT IS BEING MET,

WE HAVE ADDED TWO NEW QUESTIONS
IN THE 2011 PBP SOFTWARE

FOR MAPDs.

SPONSORS MUST INDICATE THAT THEY
EITHER HAVE A BASIC PLAN

IN THE SERVICE AREA OR THAT
THE ENHANCED ALTERNATIVE PLAN

BEING SUBMITTED MEETS THESE
REQUIREMENTS BECAUSE

A SPONSOR HAS BOUGHT DOWN
THE SUPPLEMENTAL PREMIUM TO ZERO

USING MA REBATE DOLLARS.

THIS IS A SCREEN SHOT

OF WHERE YOU WOULD
ENTER THIS INFORMATION.

SO IT'S THE LAST TWO QUESTIONS
ON THE LEFT-HAND SIDE.

PART D SPONSORS MAY OFFER
OVER-THE-COUNTER DRUGS

AS PART OF THEIR ADMINISTRATIVE
COST STRUCTURE.

SPONSORS HAVE THE OPTION OF
PROVIDING OTCs UNDER

EITHER A GENERAL UTILIZATION
MANAGEMENT STRUCTURE

OR AS A PROTOCOL SUBMITTED
FOR REVIEW AND APPROVAL BY CMS.

TO ENSURE CONSISTENCY

BETWEEN THE PBP AND FORMULARY
FILE SUBMISSIONS,

THERE IS A NEW
QUESTION REGARDING

THE TYPE OF UM STRATEGY THAT YOU
WILL BE USING FOR 2011

IN BOTH THE PBP AND ON
THE FORMULARY SUBMISSION MODULE.

THE ANSWER TO THIS QUESTION MUST
BE THE SAME ON BOTH SIDES,

AS IT WILL IMPACT VALIDATIONS

WITH REGARD TO THE FORMULARY AND
SUPPLEMENTAL FILE SUBMISSIONS.

MEDICARE ADVANTAGE ORGANIZATIONS
CANNOT OFFER THE SAME OTC

UNDER ITS SUPPLEMENTAL PART C
BENEFIT AS THEY DO

IN THEIR PART D BENEFIT.

FOR 2011, THERE IS A NEW
REQUIRED

OTC MEDICATION ATTESTATION
STATEMENT, WHICH REQUIRES

THE SPONSORS ATTEST THAT
THE OTCS COVERED

UNDER THE PART C BENEFIT ARE
SEPARATE AND DISTINCT

FROM THE OTCS COVERED UNDER
PART D.

THIS IS JUST A SCREEN SHOT

OF WHERE THE NEW UM STRATEGY
QUESTION EXISTS

AS WELL AS THE OTC MEDICATION
ATTESTATION STATEMENT.

THE PART D Rx NOTES SECTION
OF THE PBP IS INTENDED

TO BE USED VERY RARELY--
FOR PURPOSES OF CLARIFYING

INFORMATION THAT CANNOT
OTHERWISE BE INCLUDED

IN THE PBP.

FOR 2011, THE NOTES SECTION HAS
BEEN MODIFIED TO ALLOW

ONLY 225 CHARACTERS.

ANY INFORMATION ENTERED IN
THIS SECTION MUST NOT MODIFY,

QUALIFY, OR CONTRADICT ANY
INFORMATION PROVIDED IN THE PBP

NOR SHOULD IT LIMIT THE BENEFIT
IN ANY WAY.

CMS WILL NOT APPROVE ANY
INADEQUATE OR REDUNDANT NOTES

THAT ARE PROVIDED IN THIS
SECTION.

AND YOU MAY NOT MAKE--CHANGES
TO THE NOTES SECTION

AFTER BID APPROVAL.

PART D SPONSORS MAY ELECT TO

BUNDLE

HOME INFUSION PART D DRUGS
UNDER THE PART C BENEFIT.

ANY BUNDLED DRUG MUST BE
INCLUDED ON THE PART D FORMULARY

AS WELL AS THE HOME INFUSION
SUPPLEMENTAL FILE,

BOTH OF WHICH ARE SUBMITTED
VIA HPMS

THROUGH THE FORMULARY SUBMISSION
MODULE.

NEW FOR 2011, AN HPMS UPLOAD
VALIDATION WILL ENSURE

THAT ONLY THOSE DRUGS THAT ARE
APPROPRIATE FOR HOME INFUSION

WILL BE INCLUDED ON THIS
HOME INFUSION SUPPLEMENTAL FILE.

AND I WANT TO REMIND SPONSORS

THAT ANY HOME INFUSION FILE
CHANGES MUST BE MADE

IN ACCORDANCE WITH CMS GUIDANCE
FOR FORMULARY CHANGES.

AND UNAUTHORIZED HOME INFUSION
FILE CHANGES

DURING THE FORMULARY WINDOWS
WILL RESULT

IN SUPPRESSION OF YOUR FORMULARY
FROM THE PLAN FINDER DISPLAY.

SPONSORS ELECTING TO OFFER OTCs

AS PART OF THEIR ADMINISTRATIVE
COST STRUCTURE MUST UPLOAD

AN OTC SUPPLEMENTAL FILE.

FOR 2011, THE RECORD LAYOUT
FOR OTCs INCLUDES

4 NEW FIELDS RELATED

TO STEP THERAPY.

THE FIRST IS THE UM TYPE,

AND THIS IS AN INDICATOR AS
TO WHAT UM STRATEGY

YOU WILL BE USING, WHETHER THIS
IS A GENERAL UM PROTOCOL

THAT IS SORT OF A SUGGESTION
THAT A BENEFICIARY TRY A DRUG,

BUT THEY ARE NOT REQUIRED TO
TRY AN OTC

BEFORE GETTING THE PRESCRIPTION

VERSUS A STEP THERAPY PROTOCOL
THAT IS REVIEWED FOR APPROVAL

BY CMS, AND THAT WOULD THEN
REQUIRE THEM TO TAKE THE OTC

PRIOR TO THE PRESCRIPTION
PRODUCT.

THERE ARE 3 FIELDS RELATED
TO STEP THERAPY THAT ARE

ALSO FOUND IN THE STEP THERAPY
CRITERIA DOCUMENT.

THESE ARE THE ST TOTAL GROUPS,
THE ST GROUP DESCRIPTION,

AND THE ST STEP VALUE.

THE ST GROUP DESCRIPTION THAT IS
PROVIDED IN THE OTC FILE

MUST MATCH--A STEP THERAPY
GROUP DESCRIPTION THAT IS FOUND

IN A STEP THERAPY DOCUMENT
SUBMITTED WITH THE FORMULARIES.

AND THE STEP VALUE THAT MUST BE
ENTERED FOR OTCS IS 1,

MEANING IT'S
A PREREQUISITE DRUG.

IN THE UNLIKELY EVENT THAT

THE SAME OTC WOULD BE INVOLVED

IN MORE THAN ONE PROTOCOL,
THE ST GROUP DESCRIPTION

AND STEP VALUE SHOULD BE
REPEATED AS A UNIT

IN THE OTC SUPPLEMENTAL FILE,

THE SAME AS IS DONE ON
THE FORMULARY FILES.

YOU CAN REFER TO THE 2011
FORMULARY TECHNICAL MANUAL

FOR MORE INFORMATION ABOUT
THIS RECORD LAYOUT.

AND JUST AS A REMINDER,

OTC FILES WITH CONFLICTING
INFORMATION WILL BE REJECTED.

SO PLEASE MAKE SURE THAT
THE INFORMATION SUBMITTED

ON YOUR OTC FILE MATCHES

WHAT YOU PUT IN THE PBP
AS WELL AS IN THE FORMULARY.

SPONSORS ARE REMINDED THAT IF
THEY WISH TO OFFER

A DUAL ELIGIBLE SNP WITH
ZERO-DOLLAR COST SHARING

UNDER PART D, THE SPONSOR MUST
BUY DOWN THE ENTIRE 25%

ACTUARIAL EQUIVALENT COST
SHARING AMOUNT USING

MA REBATE DOLLARS IN THE BID.

PART D PLANS DO NOT HAVE
THE OPTION

OF ONLY APPLYING THE REBATE
DOLLARS

TO THE STATUTORY PATIENT PAY
AMOUNTS IN RECEIVING

FEDERAL DOLLARS FOR COST SHARING
SUBSIDIES FOR THE REMAINDER.

PART D SPONSORS ARE ALSO NOT
PERMITTED TO WAIVE

THE LIS COST SHARING AMOUNTS.

THIS IS NOT ALWAYS BID PROPERLY.

SO PLEASE TAKE NOTE THAT IF YOU
INTEND TO OFFER

ZERO-DOLLAR COST SHARING

FOR YOUR DUAL ELIGIBLE SNPs
THAT YOU ADHERE

TO THESE INSTRUCTIONS.

CMS BELIEVES THAT THERE'S
A POSITIVE RELATIONSHIP

BETWEEN PLAN PERFORMANCE
AND DIRECT ADMINISTRATIVE COSTS.

FOR THE PURPOSES OF 2011
BID REVIEWS,

CMS EXPECTS TO MORE CLOSELY
SCRUTINIZE

PROPOSED DIRECT ADMINISTRATIVE
COSTS

RELATIVE TO 2009 PERFORMANCE
MEASURES

TO ENSURE THAT PART D SPONSORS
ARE COMMITTING

SUFFICIENT FUNDING

TO ADMINISTRATIVE PROGRAMS
AND SERVICES.

A REQUEST FOR PLAN CORRECTION
INDICATES THE PRESENCE

OF INACCURACIES AND/OR
THE INCOMPLETENESS OF A BID.

AND IT CALLS INTO QUESTION

THE ORGANIZATION'S ABILITY

TO SUBMIT CORRECT BIDS AS WELL
AS THE VALIDITY

OF THE FINAL ACTUARIAL
CERTIFICATION

AND BID ATTESTATION.

CMS EXPECTS THAT SPONSORS'
REQUESTS FOR PLAN CORRECTIONS

WILL BE VERY RARE.

HOWEVER, IF YOU FIND THAT
YOU NEED TO MAKE

A PLAN CORRECTION REQUEST,
PLEASE KNOW THAT YOU WILL BE

RECEIVING A WARNING LETTER
FOR THAT REQUEST.

AND ANY ORGANIZATION THAT
SUBMITS A REQUEST FOR 2011

WHO ALSO REQUESTED CORRECTIONS
IN 2010

AND RECEIVED A WARNING LETTER

WILL RECEIVE A CORRECTIVE
ACTION PLAN.

THE PLAN CORRECTION MODULE WILL
BE AVAILABLE IN HPMS

FOR A LIMITED TIME

FROM MID-SEPTEMBER
TILL OCTOBER 1, 2010.

IT'S ONLY AVAILABLE FOR
ORGANIZATIONS

WITH AN APPROVED CONTRACT.

AND ONLY THOSE PBP CHANGES
THAT ARE SUPPORTED BY THE BPT

WILL BE ALLOWED.

Part 3

CMS REVISED ITS REGULATIONS
TO ENSURE THAT PLAN OFFERINGS

BY PART D SPONSORS REPRESENT
MEANINGFUL DIFFERENCES

TO BENEFICIARIES WITH RESPECT
TO BENEFIT PACKAGES

AND PLAN COST STRUCTURES.

FOR 2011, CMS WILL ONLY APPROVE
A BID IF THE PLAN OFFERING

BY THE SPONSOR IN
THE SAME SERVICE AREAS ARE

SUBSTANTIALLY DIFFERENT.

PDPs ARE REQUIRED TO HAVE
ONE BASIC OFFERING

IN A SERVICE AREA.

SPONSORS THAT SUBMIT MORE THAN
ONE BASIC OFFERING ARE

UNLIKELY TO BE ABLE TO
DEMONSTRATE

MEANINGFUL DIFFERENCES BASED ON
EXPECTED OUT OF POCKET COSTS.

THEY'RE ALSO UNLIKELY
TO MAINTAIN

STATUTORY ACTUARIAL EQUIVALENT
REQUIREMENTS

AND FULFILL THE REQUIREMENT
TO MAINTAIN COST-EFFECTIVE

DRUG UTILIZATION REVIEW
PROGRAMS.

THEREFORE, CMS BELIEVES SPONSORS
SHOULD SUBMIT ONE AND ONLY ONE

BASIC OFFERING FOR PDPs
IN A SERVICE AREA.

FURTHERMORE ENHANCED ALTERNATIVE

PDPs OFFERED

IN THE SAME SERVICE AREA
MUST BE SUBSTANTIALLY DIFFERENT

FROM THE BASIC PLAN AND OFFER
GREATER VALUE.

IN CONSULTATION WITH
BENEFICIARIES

AND THEIR ADVOCATES, WE'VE
LEARNED THAT IT'S BEEN

DIFFICULT FOR BENEFICIARIES
TO DISTINGUISH BETWEEN

PLAN OFFERINGS OF
THE SAME SPONSOR

WHEN COST SHARING PREMIUMS
ARE SIMILAR

BETWEEN THE ENHANCED
AND BASIC PLAN.

IN 2011, CMS WILL BE
PARTICULARLY SCRUTINIZING

LOW ADDITIONAL VALUE
ENHANCED PLANS

AS WE ARE CONCERNED THAT SOME
OF THESE PLANS ARE

NOT UNDERSTOOD BY BENEFICIARIES
IN TERMS OF EXPECTED VALUE

AND MAY NOT BE MEANINGFULLY
DIFFERENT FROM BASIC OFFERINGS.

TO DETERMINE IF OFFERINGS RESULT
IN MEANINGFUL DIFFERENCES

IN THE 2011 CONTRACT TIER, CMS
WILL COMPARE PLAN OFFERINGS

BY THE SAME SPONSOR
IN A SERVICE AREA

BY EVALUATING EXPECTED OOPC
AMOUNTS UNDER EACH OFFERING.

WE WILL DO THIS BY UTILIZING

A UNIFORM BASKET OF MARKET DRUGS

FROM A REPRESENTATIVE POPULATION
OF MEDICARE BENEFICIARIES.

AND WE WILL ESTIMATE OOPCs BASED
ON EACH PLAN'S BENEFIT DESIGN.

USING THESE 2010 OOPC VALUES,
WHICH WILL BE AVAILABLE SOON

IN HPMS FOR YOUR REVIEW, CMS FOUND
THAT THOSE PLANS OFFERING

A SUPPLEMENTAL ENHANCED BENEFIT,

INCLUDING COVERAGE OF AT
LEAST SOME GENERICS--

THIS DESCRIPTION I PRESENTED TO
YOU ON AN EARLIER SLIDE,

WHEN WE WERE TALKING ABOUT GAP
COVERAGE LEVEL DESCRIPTIONS--

THEY FOUND THAT WHEN COMPARED
TO A BASIC OFFERING

IN THE SAME AREA, THERE WAS
\$22 LESS

IN EXPECTED MONTHLY
OUT-OF-POCKET COSTS

FOR THE ENHANCED PLAN.

BASED ON THESE FINDINGS
FOR 2011 BID NEGOTIATIONS,

CMS EXPECTS OOPC PLAN
DIFFERENTIALS BETWEEN

A BASIC AND ENHANCED OFFERING
WITHIN THE SAME SERVICE AREA

TO AT LEAST BE A \$22 DIFFERENCE
PER MONTH

OR \$264 ANNUALLY.

IN ADDITION, ANY PLAN WITH
A SECOND ENHANCED OFFERING

IN THE SAME SERVICE AREA

MUST DEMONSTRATE

A HIGHER VALUE THAN THE FIRST
AND MUST INCLUDE AT LEAST

SOME BRAND DRUGS
COVERED IN THE GAP.

SPONSORS WHO INTEND TO OFFER
MULTIPLE PLANS SHOULD CALCULATE

AND COMPARE OOPCs FOR A SET
OF BASKET DRUGS

AND A CONSTANT GROUP OF
BENEFICIARIES ALREADY ENROLLED

IN YOUR ORGANIZATION.

SPONSORS MAY ALSO WANT TO REVIEW

THEIR OWN 2010 CMS OOPC
CALCULATIONS AND TARGET

NECESSARY REVISIONS IN THE PBP
PRIOR TO SUBMISSION NEXT MONTH.

CMS WILL SCRUTINIZE
LOW-ENROLLMENT PDPs

DURING THE BID REVIEW PERIOD,
PARTICULARLY THOSE PLANS

THAT CONSTITUTE THE LOWEST 20%
OF ENROLLMENT FOR 2010.

CMS EXPECTS THAT SPONSORS WILL
HAVE WITHDRAWN OR CONSOLIDATED

LOW-ENROLLMENT PLANS PRIOR
TO SUBMITTING BIDS FOR 2011,

ESPECIALLY THOSE PDPs WITH LESS
THAN 1,000 ENROLLEES.

THIS GUIDANCE APPLIES TO
NON-EMPLOYER STAND-ALONE PDPs.

HOWEVER, WE RESERVE THE RIGHT
TO RECONSIDER THE WAIVER GRANTED

FOR EMPLOYER GROUP PLAN SPONSORS
IN THE FUTURE.

CMS UPDATED ITS REGULATIONS TO
SPECIFY THAT TIERED COST SHARING

FOR NON-DEFINED STANDARD BENEFIT
DESIGNS MAY NOT EXCEED

LEVELS ANNUALLY DETERMINED
BY CMS TO BE DISCRIMINATORY.

TO THIS END, CMS WILL EXAMINE
2011 PDP AND MA-PDs TO DETERMINE

ACCEPTABLE COST SHARING
THRESHOLDS.

THE 2010 THRESHOLDS ARE LISTED
ON THIS SLIDE

FOR TIERS 1 THROUGH 3, OF \$10,
\$45, AND \$95 RESPECTIVELY.

CONSISTENT WITH PRIOR YEARS, WE
WILL CONDUCT ANALYSES

TO IDENTIFY COST-SHARING
OUTLIERS

RELATIVE TO OTHER SPONSORS'
COMPETING BENEFIT PACKAGES.

WHEN REVIEWING ANY OUTLIERS,
CMS WILL TAKE INTO CONSIDERATION

SPECIFIC BENEFIT DESIGN ASPECTS
THAT MAY JUSTIFY AN EXCEPTION

OF THE ESTABLISHED 2011
THRESHOLDS.

FOR EXAMPLE, ATYPICAL TIERING
OR TIER STRUCTURES THAT INCLUDE

LOWER COST-SHARES
ON HIGHER TIERS.

NEW FOR 2011--CMS WILL INCREASE
SCRUTINY OF THE EXPECTED

COST SHARING AMOUNT INCURRED
BY BENEFICIARIES

UNDER COINSURANCE TIERS

IN ORDER TO MORE CONSISTENTLY

COMPARE

CO-PAY AND COINSURANCE
COST-SHARING IMPACTS.

WE EXPECT TO DERIVE AVERAGE
EXPECTED COST SHARING AMOUNTS

FOR 2011 COINSURANCE TIERS
USING 2009 PDE DRUG COST DATA

MAPPED TO YOUR 2011 FORMULARY.

IF A SPONSOR SUBMITS
COINSURANCE VALUES

INSTEAD OF CO-PAYMENT VALUES,

CMS MAY ALSO REQUEST
DOCUMENTATION FROM A SPONSOR

ON THE AVERAGE EXPECTED COST
FOR MEDICATIONS

ON THE COINSURANCE TIERS DURING
OUR BENEFIT REVIEW.

BEFORE CLOSING, I WANTED TO
BRIEFLY TOUCH ON COMPLIANCE

WITH CMS FORMULARY AND BENEFIT
POLICY AND GUIDANCE.

WE ARE FINDING MORE AND MORE
THAT SPONSORS ARE

NOT ADMINISTERING THEIR BENEFIT
AS SUBMITTED AND APPROVED

BY CMS.

THE AREAS OF NONCOMPLIANCE RANGE
FROM FORMULARY SUBMISSIONS

TO MARKETING TO CLAIMS
PROCESSING.

I'VE INCLUDED SOME OF THE AREAS
OF PARTICULAR CONCERN

IN THE FOLLOWING SLIDES.

WE HAVE NOTICED THAT SOME
SPONSORS HAVE FAILED TO ADD

PROTECTED CLASS DRUGS TO THEIR
FORMULARIES.

SPONSORS MUST ADD PROTECTED
CLASS DRUGS TO THE FORMULARY

BY THE END OF THE 90-DAY
EXPEDITED REVIEW PERIOD

AS OUTLINED IN THE CY 2010
FORMULARY UPDATE MEMO ISSUED

IN JANUARY OF LAST YEAR.

WE'VE ALSO FOUND A FAILURE TO
ADHERE TO CMS TRANSITION POLICY.

AGAIN, SPONSORS ARE REQUIRED TO
HAVE A TRANSITION PROCESS

CONSISTENT WITH CMS POLICY AS
OUTLINED IN CHAPTER 6,

AND TO WHICH THEY
HAVE ATTESTED TO.

AND JUST EXPOUNDING ON THIS,
ATTESTATIONS WERE DUE FOR 2011

LAST NIGHT AT MIDNIGHT.

AND WE'VE ALREADY FOUND THAT
AT LEAST 30 CONTRACTS

HAVE NOT COMPLETED THEIR
ATTESTATIONS

FOR THEIR TRANSITION IN HPMS.

SO THESE CONTRACTS WILL
BE RECEIVING

A NOTICE OF NONCOMPLIANCE.

WE'VE ALSO FOUND

UTILIZATION OF UNAPPROVED PRIOR
AUTHORIZATION

AND/OR STEP THERAPY EDITS
AND CRITERIA.

AGAIN, ONLY THOSE PRIOR

AUTHORIZATION

OR STEP THERAPY CRITERIA
OR EDITS THAT HAVE BEEN APPROVED

BY CMS CAN BE IMPLEMENTED.

AND SPONSORS CANNOT OPPOSE
ADDITIONAL EDITS

WITHOUT EXPLICIT APPROVAL BY CMS
REGARDLESS OF WHETHER OR NOT

YOU THINK

THEY'RE CLINICALLY APPROPRIATE.

FINALLY WE FOUND PROBLEMS
WITH MARKETING MATERIALS

IN TERMS OF THEIR CONSISTENCY
TO THE APPROVED FORMULARY

BOTH IN TERMS OF THE CONTENT
AS WELL AS THE PRIOR AUTH

AND STEP THERAPY CRITERIA
THAT'S LISTED

IN THE MARKETING MATERIALS.

WE'VE FOUND FAILURE TO PROCESS
CLAIMS IN ACCORDANCE

WITH THE APPROVED FORMULARY,
AGAIN IN TERMS

OF THE CONTENT, THE TIERING,
AS WELL AS THE PRIOR AUTH

AND STEP THERAPY
THAT'S ADMINISTERED

AT THE POINT OF SALE.

AND WE'VE FOUND INADEQUATE
OVERSIGHT OF SUBCONTRACTORS.

AND WE JUST WANT TO
REMIND SPONSORS

THAT IT IS YOUR RESPONSIBILITY
TO ENSURE

THAT YOUR SUBCONTRACTORS
UNDERSTAND AND COMPLY

WITH CMS POLICY.

ANY OF THESE ERRORS OR OFFENSES
COULD RESULT

IN COMPLIANCE ACTION

AND MAY WARRANT FURTHER
INVESTIGATION

INTO YOUR PLAN PRACTICES IF WE
FIND THAT ARE YOU DOING

ANY OF THESE OR ANY OF THE LIST
OF OTHER INFRACTIONS.

OK. THAT CONCLUDES MY
PRESENTATION.

IF YOU HAVE ANY QUESTIONS
REGARDING THIS PRESENTATION

OR ANY OTHER GENERAL
BENEFIT-RELATED QUESTIONS,

YOU CAN E-MAIL THEM TO...

ALTERNATIVELY YOU COULD CONTACT
MYSELF OR ROSALIND ABANKWAH

OR FRANK TETKOWSKI AT THE
PHONE NUMBERS OR EMAIL ADDRESSES

PROVIDED. THANK YOU.