Memorandum

To: Department of Health and Human Services, Centers for Medicare & Medicaid Services

From: Health Partners Plans

Date: 06/14/2018

Re: Release of 2019 Part C and D Regulation for Public Comment - Proposed Rule

Health Partners Plans (HPP) would like to thank the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) for the opportunity to provide feedback on the Release of 2019 Part C and D Regulation for Public Comment - Proposed Rule. Our various business units and subject matter experts have carefully reviewed the proposed rule and believe we have provided useful feedback. We welcome any questions or concerns should you need additional clarification.

HPP generally supports this initiative and agrees that this proposal would create efficiencies in the administration of services and improve program integrity for Medicare Part C and D. Although we are generally supportive of the initiative, we feel implementation of the requirements of the proposed rulemaking presents an opportunity to address specific concerns, which are outlined below. As well, HPP would like to offer recommendations to further strengthen consistency in administration of Part C and Part D programs. In addition to the recommendations offered, we have included questions pertaining to selected provisions of the proposed rulemaking.

**Comments on Proposed Rule**

**Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions – Summary of the Major Provisions.**

Regarding CMS’ proposal to establish a drug management program for beneficiaries at risk of prescription drug abuse or misuse, in which access to coverage of controlled substances that are “frequently abused drugs” be restricted to selected prescribers or network pharmacies, HPP believes that restricting a select set of drugs would be difficult. Typically, when medications are restricted to a specific prescriber or pharmacy, it applies to all medications taken by the beneficiary. An overutilization management system applicable to opioids is currently in place, but it is not restricted to a specific prescriber or pharmacy. Restricting all medications may be more effective and simpler to operationalize.

**Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions – Medicare Part D Drug Management Programs.**

HPP supports the proposals in this provision.

**Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions – Integration of CARA and the Current Part D Opioid DUR Policy and OMS – Clinical Guidelines and Program Size (§ 423.100).**

This will increase the number of identified “at risk members”, which HPP supports.

**Requirements for Limiting Access to Frequently Abused Drugs (§ 423.153(f)(4)).**

HPP believes that gaining agreement from prescribers and/or pharmacies will cause delays in beneficiary lock-in, and will require follow-up with prescribers to gain agreement, and repeat the process if the first prescriber does not consent. HPP would appreciate clarification of the appropriate action steps if the prescriber does not consent and whether another prescriber would be selected.

**Special Requirement to Limit Access to Frequently Abused Drugs to Selected Prescriber(s) (§ 423.153(f)(4)).**

HPP believes the 6-month waiting period proposal to account for time needed for the case management process is overly burdensome for plans and will prove difficult to operationalize. It is requested that plans be afforded flexibility to conduct case management and implementation of edits in a manner best suited for prescribers and beneficiaries.

Concerning notifications, will CMS provide templates for plan use, as is currently in place?

It is additionally requested that CMS create a dedicated manual for all regulations and guidelines for OMS. Current prevailing guidelines are contained in call letters and memos, many of which cancel or contradict one another. A single source would best ensure compliance.

**Reasonable Access (§§ 423.100, 423.153(f)(11), 423.153(f)(12).**

CMS is proposing to address chain pharmacies and group practices by adding a paragraph (ii) that states: (ii) (A) For purposes of this subsection (f)(12) of this section, in the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy; and (B) For purposes of this subsection (f)(12), in the case of a group practice, all prescribers of the group practice shall be treated as one prescriber.

HPP believes this proposal will be extremely difficult to implement. Pharmacies sharing real-time data may not share anything in common systematically other than their name, and that may not apply to all cases. Identifying pharmacies who meet this criterion will be difficult, but coding them into a system which allows for meaningful reporting to eliminate false positives will be even more so. \Counting data-sharing pharmacies as one because pharmacies may share real-time data does not ensure that the dispensing pharmacist will always check. It is recommended that pharmacies should be counted solely by NPI.

**Confirmation of Pharmacy and Prescriber Selection (§ 423.153(f)(13).**

It is recommended that CMS propose minimum requirements that pharmacies must meet to participate in drug management programs for at-risk beneficiaries.

**Termination of a Beneficiary’s Potential At-Risk or At-Risk Status (§ 423.153(f)(14)).**

CMS is proposing a maximum 12-month period for both a lock-in period, and also for the duration of a beneficiary-specific POS claim edit for frequently abused drugs through the addition of the following language at § 423.153(f)(14): Termination of Identification as an At-Risk Beneficiary. The identification of an at-risk beneficiary as such shall terminate **as of the earlier of the following**—

(i) The date the beneficiary demonstrates through a subsequent determination, including but not limited to, a successful appeal, that the beneficiary is no longer likely, in the absence of the limitations under this paragraph, to be an at-risk beneficiary; or

(ii) The end of a 12 calendar month period calculated from the effective date of the limitation, as specified in the notice provided under paragraph (f)(6) of this section.

The proposed verbiage is clear that it is possible the at risk status will terminate earlier than 12 months if a beneficiary demonstrates through a subsequent determination that the beneficiary is no longer likely to be an at-risk beneficiary.

HPP would like for CMS to clarify whether there will be a **minimum** lock-in period established.

**Part D Tiering Exceptions (§§ 423560, 423.578(a) and (c)). Additional Technical Changes and Corrections.**

Currently, Chapter 6, Section 30.2.1.4 of the Medicare Prescription Drug Benefit Manual provides examples to illustrate possible cost-sharing tier structuresand permissible tiering exceptions between the tiers. HPP requests that CMS further expand on each possible tiering exception scenario for the various formulary set-ups; this will likely eliminate any ambiguity regarding interpretation of the language.

**Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy Types (§§ 423.100, 423.505). Revise the Definition of Retail Pharmacy. Add a Definition of Mail-Order Pharmacy.**

We agree with the proposed revision of retail pharmacy and to the new definition of mail-order pharmacy.

The proposed definitions should be objective to allow pharmacy audits by PBMs. As an example, if a pharmacy exceeds thresholds that are used to define retail versus mail-order, the thresholds are objective in order to be auditable.

We suggest that the final rule include the comment that the revised definition is for the pharmacy’s primary model of operation. Best practices suggest pharmacies use a unique NPI/NCPDP ID for each designation. However, we ask CMS to recognize that a pharmacy may operate as multiple types (e.g., retail and home infusion). The current NCPDP Telecommunications standard named under HIPAA for pharmacy claims submission allows the pharmacy to designate the appropriate pharmacy service type at a claim level. This enables the plan to determine under which network the claim is processed for reimbursement and allows pharmacies to be held accountable at a claim level to the threshold associated with that designation.

**Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy Types (§§ 423.100, 423.505). Treatment of Accreditation and Other Similar Any Willing Pharmacy Requirements in Standard Terms and Conditions.**

HPP believes the any willing provider model effectively eliminates the incentive for a pharmacy to supply a cost outlay for an innovative program. A pharmacy and a plan may work together to enhance the treatment of diseases and the dispensing of non-urgent, readily available medications (e.g., Hepatitis C) can be undermined by the corner pharmacy trying to solicit as many prescriptions as possible from physician offices to make a profit.

Additionally, CMS’ proposal would require communication of standard credentialing criteria to be provided to plans and PBMs. Additional accreditation that supports access needs (e.g., plans that operate in areas with multiple language requirements or plans with high volumes of disabled patients requiring special access support) should be allowed.

**Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy Types (§§ 423.100, 423.505). Timing of Contracting Requirements.**

CMS proposes that Part D plans have standard terms and conditions readily available for requesting pharmacies no later than September 15 of each year for the succeeding benefit year; after that date and throughout the following plan year, Part D plans must also provide the applicable standard terms and conditions document to a requesting pharmacy within two business days of receipt of the request.

We agree the proposed turnaround time for providing standard terms to a requesting pharmacy is reasonable. However, we recommend that proposed annual timing for availability of contracting requirements be no later than 30 days prior to the start of the succeeding benefit year. We additionally recommend that the turnaround time be dependent on the requesting pharmacy providing valid contact information and that the start of the turnaround time period would begin when the plan has obtained the valid delivery information (e.g., email, fax number, mailing address) from the requesting pharmacy.

**Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic and LIS Cost Sharing.**

HPP supports the proposed change to the definition of generic drug at § 423.4.

**Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale**

The proposed rule requires that a percentage of rebates and all pharmacy price concessions be applied in real time at point of sale (POS). Rebates (market share influenced) and performance-based pharmacy price concessions require no less than a full year of experience to calculate the actual reimbursement as full reconciliation of rebates. Plans will need to project these performance-based amounts and allocate them to a claim level at POS. Sharing rebates and pharmacy arrangements with the beneficiary at POS would drive up premiums for all beneficiaries, as well as other program costs.

Plans will also assume the risk in offering the rebate and pharmacy price concession at POS, as these amounts are not available to plans until reconciliation, which occurs numerous months after the POS event. The projected performance-based concessions for both rebates and pharmacy arrangements will have to be reflected in the bid. Should the plan not project the costs for rebates or pharmacy concessions correctly, the bid amount could be affected. Even small errors in bid amounts could make a plan less marketable to the Part D population. Loss of market share and plan uncertainty could cause plan withdrawals in a manner similar to the Affordable Care Act (ACA) market. In addition, any failure to correctly identify the rebates and pharmacy price concessions at POS, or a change in market or contract conditions that affect projected amounts, could result in the use of incorrect or inaccurate POS amounts, which could then have a potentially significant effect on beneficiary cost-sharing, out-of-pocket and phases of coverage.

This proposed arrangement may create disincentives for plans to offer new or extended value-based arrangements because of possible risk allocations. New arrangements will have no claim experience from which to base a projection, and errors in projecting the value of such a program through POS and the plan bid could cause membership issues, including a real loss of membership. Plans may be discouraged from continuing or expanding their value-based arrangements because of the uncertainty of savings, which seems contrary to CMS’ moving plan reimbursement from a “fee for services” to “pay for performance” model. Attempts to implement innovative and new programs with potential benefits to member health, and member and government costs, may be stymied because the anticipated, yet unproven benefits of such a program would need to be calculated and applied up front, rather than after the establishment of performance and success. As a result, plans would be at risk for the full failure of such programs and efforts, rather than having the opportunity to put arrangements in place to prove and establish their value.

Finally, while an allocation at POS may appear on the surface as a straightforward process, this would require substantive changes to business practices and systems throughout the industry. Many, if not most, (claims) processing and financial systems do not currently handle this (whether manufacturer, pharmacy, processor, etc.), and the complexity and cost of doing so would be substantial.

Outside of the potential plan effects, there are also technical challenges to implementing this at POS. The HIPAA-mandated transaction standard for pharmacy claim submission, the NCPDP Telecommunication standard, does not contain fields on the claim response to report pharmacy price concessions.

The X12 835 5010 transaction, the HIPAA mandated transaction for communicating pharmacy remittance, contains fields to report amounts back at the claim level and allows adjustments that reduce the amount paid. Price concessions can be reported on the 835 transaction with the corresponding claim level adjustment reason codes. Some price concessions are only calculated at the pharmacy store level and therefore adjusted at the store level, not at the claim level on the 835 transaction. Modifications to the NCPDP Telecommunication standard and the X12 835 may be needed to ensure the exchange of rebate and price concessions at POS. As both the NCPDP Telecommunication standard and the X12 835 standard are HIPAA-named transactions, the process and timelines for implementing changes to those standards will prohibit timely communication of a POS solution for returning rebate and pharmacy price concessions.

**Part D Prescriber Preclusion List Provisions (§ 423.120).**

HPP disagrees with the proposed effective date of January 1, 2019. Based on the proposed rule changes, additional Reject Codes and possible Submission Clarification Codes (SCCs) will need to be implemented by the National Council for Prescription Drug Program (NCPDP). There will be insufficient time for NCPDP to implement new codes by January 1, 2019, following issuance of the final regulation. As well, we disagree with the proposed effective date due to the many questions regarding how the proposed rules are to be administered. An effective date of no earlier than January 1, 2020 is recommended, and a minimum of 18 months after publications of the necessary technical guidance and confirmed file layouts. It is also requested that CMS adopt the precluded operational process outlined by NCPDP in order to have a consistent industry approach.

Questions

* The preclusion list is proposed to be updated monthly. If a prescriber appeals placement on the preclusion list, will it require a month for the prescriber to be removed from the list?
* Do processors continue to deny claims if provisional fills have been granted?
* Will the preclusion list be published on a public site or a restricted site that only plans can access (e.g., CMS MED files)?
* Will the preclusion file include termination dates as well as effective reinstatement dates, or will the prescriber be removed from the file upon reinstatement?

Part D claim rejections by Part D plans and their PBMs under § 423.120(c)(6) would only apply to claims for Part D prescriptions filled or refilled on or after the date of addition to the prelusion list.

Questions

* How will this affect a dual-eligible or Medicare-Medicaid Program (MMP)?
* Can the drug be covered under Medicaid, or will the rule apply to both lines of business?

Regarding CMS’ proposed revisions to provisional coverage, please note the following questions:

* A beneficiary fills a prescription on January 1, starting the 90-day provisional period. On March 15, may the beneficiary obtain a refill or a new fill from the same prescriber for a 90-day supply?
* Would a beneficiary only receive drug quantities to extend through March 31, the end of the proposed 90-day provisional coverage period?
* Is a letter for provisional coverage only required with the first drug fill and not the first drug fill of each different drug?

Regarding the proposal stating “. . . a Part D sponsor must reject, or must require its PBM to reject, a pharmacy claim for a Part D drug if the individual who prescribed the drug is included on the preclusion list. . ,” please note the following questions:

* What is the hierarchical order of processing: Office of Inspector General (OIG), Office of Personnel Management (OPM), Preclusion List?
* Is it possible that a prescriber could be on more than one list and thereby create overlap between precluded providers and the CMS provider exclusion file?
* We recommend that CMS define the technical details outlined by NCPDP and allow an implementation timeline with a minimum of 18 months after publication of the necessary technical guidance and confirmed file layouts.

Regarding the proposal stating “. . . a plan sponsor may not submit a prescription drug event (PDE) record to CMS unless it includes on the PDE record the active and valid individual NPI of the prescriber of the drug, and the prescriber is not included on the preclusion list,” please note the following questions:

* Does the type of fill and prescriber type still need to be included in the PDE as previously outlined?
* For PDE editing, will CMS use the creation date of the preclusion file or will it be based on the active preclusion file when the PDE is processed?

Regarding proposals affecting the provisional coverage period and notice provisions, please note the following question:

* For claims submitted after the provisional coverage period, would these claims receive NCPDP Reject Code 569 (Provide Notice Medicare Prescription Drug Coverage and Your Rights) or Reject Code 829 (Pharmacy Must Notify Beneficiary: Claim Not Covered Due To Failure To Meet Medicare Part D Active, Valid Prescriber NPI requirements)?

**Limitation on the Special Enrollment Period for LIS Beneficiaries with an At-Risk Status (§423.38).**

CMS proposes a framework under which Part D plan sponsors may establish a drug management program for beneficiaries at risk for prescription drug abuse or misuse, or "at-risk beneficiaries." CMS is proposing to limit the use of the special enrollment period (SEP) for dually- or other low income subsidy (LIS)-eligible beneficiaries who are identified as at-risk or potentially at-risk for prescription drug abuse under such a drug management program. The duals’ SEP currently allows such individuals to make Part D enrollment changes (that is, enroll in, disenroll from, or change Part D plans) throughout the year, unlike other Part D enrollees who generally may make enrollment changes only during the annual election period (AEP). Individuals using this SEP can enroll in either a stand-alone Part D prescription drug plan (PDP) or a Medicare Advantage plan with prescription drug coverage.

This proposed rule would implement a limitation on the use of the special enrollment period (SEP) for low income subsidy (LIS)-eligible beneficiaries who are identified as potential at-risk beneficiaries. We understand that this proposed SEP limitation would be an important tool to reduce the opportunities for LIS-eligible beneficiaries designated as at-risk to switch plans. If an individual is determined to be an at-risk beneficiary, and is permitted to change plans using the duals’ SEP, he or she could avoid the drug management program by leaving the plan before the program can be started or by enrolling in a PDP that does not have a drug management program.

When it states “CMS proposes to limit the use of the SEP for beneficiaries who are identified as at-risk or potentially at-risk for prescription drug abuse under such a drug management program”, it remains unclear if it is incumbent upon a sponsor’s Enrollment department to know that a beneficiary is ineligible for enrollment/ disenrollment, or if the MARx system store an indicator, preventing the SEP from being used.

HPP is seeking clarification on the aforementioned proposal. Provided below is a description of the associated operational concerns.

As stated in the proposed rule, implementation of the limitation means that the individual would be unable to use the duals’ SEP to enroll in a different plan or disenroll from the current Part D plan. Unless there is an indicator stored in the MARx system, a new plan would not be aware that an individual is not able to enroll due to being “potentially at risk” or “at risk”. The new plan would simply process the enrollment transaction, which would cause the beneficiary to be disenrolled from their existing plan due to enrollment into another plan. In such cases, CMS would need to either store an indicator in MARx to prevent the beneficiary from enrolling, or create a transaction reply code to reject the enrollment transaction and clearly explain to the sponsor the reason for the denial.

As it relates to the current plan sponsor processing disenrollment transactions, it may be operationally burdensome for a sponsor’s Enrollment department to proactively identify beneficiaries impacted by the drug utilization program prior to effectuating a disenrollment transaction, and instead locking the beneficiary in. In the event it is left up to the sponsor’s Enrollment department to determine whether or not the beneficiary is ineligible to disenroll due to their at risk status, CMS would need to allow sufficient time for plans to operationalize such a requirement since it would require substantial and potentially costly system reconfiguration. Plans typically capture their drug management progressions in the PBM systems, which is typically separate from the front end enrollment processing system. Depending on the organization, access to a PBM’s system is limited to appropriate personnel, which typically does not include Enrollment staff. Therefore, plans would need to develop a way to store indicators in the PBM system that could systemically transmit to either the front end enrollment processing systems or a centralized system that receives data from both sources.

While we agree this may be an appropriate step to ensure at risk beneficiaries are effectively case managed, we still feel it is worthwhile to raise the operational concerns associated with such an implementation.

A practical solution that would be both effective and less burdensome may be for CMS to add an indicator into MARx that would ultimately result in rejecting both enrollment and disenrollment transactions from being processed when the beneficiary is classified as “potentially at risk” or “at risk” and the election period code transmitted is “U - for Duals and Individuals with LIS”. CMS could also include both a start and end date that would indicate the timeframe in which the beneficiary is ineligible to utilize the election period.

**Reducing the Burden of the Compliance Program Training Requirements (§§422.503**

**and 423.504).**

HPP agrees with CMS that the implementation of the mandatory CMS-developed General Compliance training has not achieved the intended efficiencies in the administration of the Part C and Part D programs. We support CMS’ proposal to delete the provisions from the Part C and Part D regulations that require use of the CMS-developed training. As a Medicare Advantage Organization that seeks to ensure our FDRs, including network providers, comply with regulatory requirements, we’ve often received feedback that the need to take the CMS version of both the Fraud, Waste and Abuse training, as well as the General Compliance training places increased the burden on these vendors since the training is not generic enough to accommodate all product types the vendor performs services for (e.g. Medicare Part C & D, Medicaid, CHIP, and Commercial). Because of this, vendors have been continuing to take both the MLN version to satisfy Medicare requirements and additional versions to address the needs of other product lines. While it was intended to ease the burden, it seems to have only modified the burden.

Additionally, in order to ensure consistency in Compliance Program Training, we ask CMS to confirm that any proposed revisions to the language be reflected in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

**Revisions to Timing and Method of Disclosure Requirements (§§ 422.111 and 423.128).**

Health Partners Plans supports CMS’ proposal to revise §§ 422.111(a)(3) and 423.128(a)(3) to require MA plans and Part D Sponsors to provide the information in paragraph (b) of the respective regulations by the first day of the annual enrollment period, rather than 15 days before. Furthermore, we support the posting of documents such as the EOC, Summary of Benefits, and provider/ pharmacy directories on the plan’s website; opposed to mailing the hard copy documents to the full population, permitted plans deliver a hard copy notice describing how the information and materials are available. Not only will this approach enable plans to take advantage of technological developments and reduce the amount of mail enrollees receive from plans, it will alleviate member frustration stemming from the receipt of such large, relatively complex documents. Additionally, relaxing the requirement will afford plans the opportunity to cut down on print production costs resulting from the fulfillment of these robust materials.

In addition to supporting the above proposal from CMS, we support CMS’ decision not to revise the timeframe issuance requirements associated with the mailing of the ANOC. We agree the ANOC is essential to an enrollee’s decision to remain enrolled in the same plan for the following year or choose another plan during the AEP; therefore, 15 days prior to the start of AEP remains appropriate. Moreover, we agree enrollees are less likely to review the ANOC when accompanied by other large documents, such as the EOC. By separating the ANOC from the EOC, more enrollees will likely review the ANOC. We are hopeful this strategy will help reduce calls received during the new-year once enrollees realize they are subjected to different cost-sharing and/ or plan rules they were not familiar with due to not having reviewed the ANOC.

**Medicare Advantage and Part D Prescription Drug Plan Quality Rating System (J. Improvement Measures).**

HPP recommends that CMS consider an increase to the Categorical Adjustment Index (CAI) values for the top two tiers (Categories F and G) in order to have a more significant impact to the overall Stars scores. While HPP appreciates the findings and analysis produced by CMS regarding the impact on the measures (high CAI versus low CAI plans), the underlying efforts to move the needle are significantly different, and the cost/efforts associated with promoting beneficiary compliance are significantly difficult with additional socioeconomic and administrative challenges in servicing this population. We believe the focus of a future analysis should be on these challenges versus the outcomes.

In addition, HPP recommends that CMS consider devising an improvement score for measures that could potentially be part of the improvement measures but only have one year worth of data (2018 but not 2017). Although there is no basis for “improvement” from the previous year, we believe that a plan that obtains high scores in any of these measures, in the current measurement year, should not be excluded from the calculation. The improvement measures are high impact measures (weight 5.0), and efforts should occur within the first year to increase the quality associated with these measures in the first program year of inclusion.

**Medicare Advantage and Part D Prescription Drug Plan Quality Rating System (L. Measure-Level Star Ratings).**

HPP agrees with the current methodology in use, but would recommend that the benchmarks be made available during the measurement year (or as close to it as possible). Currently, the release of the benchmarks occurs with the results (October) for the previous year. Plans are not able to readjust priorities and efforts to affect the measures for that year, and have only two months to potentially adjust the current year performance. HPP believes that CMS should follow the NCQA guidelines for releasing benchmarks during Plan Preview 1, if not earlier. This would allow plans to better allocate resources to address low performance and improve the quality of service delivery.

**Medicare Advantage and Part D Prescription Drug Plan Quality Rating System (Q. Measure Weights).**

HPP does not support the recommendation to increase the weighting of the patient experience measures due to the volatile nature and adverse impact for plans in the high end of the CAI categories. In addition, due to the low response rates/sample size of the satisfaction surveys, overall outcomes could be significantly affected. HPP believes the focus of the Stars rating program should remain on the quality-based measures (e.g., HEDIS) and that plan measurement should be focused on delivery of care outcomes.

**Removal of Quality Improvement Project for Medicare Advantage Organizations (§ 422.152).**

HPP supports the CMS recommendation to remove QIPs.

**Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities. Revising the Scope of Subpart V to Include Communications and Communications Materials**

The meaning of the sentence below, in the final bullet on Page 362 (see below), is unclear. Is there an error in the wording?

*“For markets with a significant non-English speaking population, provide materials, as defined by CMS, unless in the language of these individuals.”*

**Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities. Prohibition of Marketing During the Open Enrollment Period.**

Regarding the Cures Act prohibition on unsolicited marketing to individuals eligible for the new OEP (Pages 368-369), HPP shares CMS’ concern in that the imposition of an overall prohibition on marketing mailings during this period could be overly broad. The limitations would apply to MA enrollees and to any PDP enrollee who was enrolled in an MA plan the prior year. Implementing these marketing limitations could prevent a plan from sending marketing mailings to individuals who are not enrolled in a plan, but would otherwise be eligible (e.g., age-ins). It is important to note that a purchased mail list could not accurately exclude individuals already enrolled in a Medicare Advantage plan.

Questions:

* Could there be exceptions to such a prohibition for marketing mailings intended to reach individuals eligible to enroll in an MA plan outside of using the OEP election period (e.g., a targeted age-in mailing)?
* Related to this, has the time period for such a prohibition been defined? (Would this prohibition begin January 1, or as soon as the AEP ended? Would it run through March 31?)