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January 13, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert Humphrey Building
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-4144-P, Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes, Federal Register, Vol. 75, No. 224, November 22, 2010

Dear Dr. Berwick:

The National Center for Assisted Living (NCAL) and the American Health Care Association (AHCA) would like to commend the Centers for Medicare & Medicaid Services (CMS) for proposing to implement Sec. 3309 of the Affordable Care Act (ACA) on Jan. 1, 2012, which is the earliest possible date that this provision may be implemented under the statute. Sec. 3309 will eliminate cost sharing under the Medicare Part D prescription drug program for an estimated 600,000 dual eligible beneficiaries receiving home and community-based (HCB) services. Sec. 3309 will bring needed relief to this vulnerable group of very low-income seniors and people with disabilities and improve their medical care. It also will also create parity in Part D cost sharing requirements between beneficiaries in institutional and HCB settings.

AHCA/NCAL greatly appreciates the opportunity to comment on this notice of proposed rulemaking. We represent more than 11,000 non-profit and for-profit providers dedicated to continuous improvement in the delivery of professional and compassionate care for our nation's citizens who are frail, elderly, or have developmental disabilities (DD) who live in nursing facilities, assisted living residences, subacute centers, and homes for persons with DD.

Background & Rationale for Sec. 3309

As CMS notes on p. 71204 of the Nov. 22, 2010 Federal Register, the Medicare Modernization Act, which created the Part D program, established that full-benefit dual eligibles living in

institutional settings have no cost sharing for covered Part D drugs. Recognizing the vulnerability of very low-income people living in institutional facilities such as nursing homes, Congress exempted dual eligibles in these settings from any cost-sharing.

Unfortunately, the original Part D legislation, implemented January 2006, required copayments for a similar population of dual eligible beneficiaries living in HCB settings such as assisted living communities, group homes, single-family homes, and apartments, even though this population usually qualifies for Medicaid, in part, by being "nursing-home eligible" and has similar needs, incomes, and vulnerabilities as beneficiaries living in institutions. Like nursing home residents receiving Medicaid services, the dual eligibles in assisted living and other HCB settings have very limited financial resources, often just a few dollars a month from a personal needs allowance.[1] For some of these people, the aggregate amount of their Part D co-payments exceeds their monthly personal needs allowance.

As detailed below, residents in nursing homes and assisted living and residential care use a similar number of prescriptions—approximately 8-10 a month. Because of their extremely low financial resources and high level of medication use, even Part D co-payments of $1.10-$6.30 per prescription (the amounts levied on this income group under the program in 2010) can present financial hardships for dually eligible assisted living and other HCB beneficiaries, and can impede people from receiving needed medications.

Medication Use among Dual Eligibles in Long Term Care Settings

Table 1 and supporting data below, which show estimates of the prescribed medication use among dual eligible individuals in long term care settings, were produced by the Lewin Group as part of a cost estimate of legislation that was proposed in 2006 to eliminate Part D cost sharing for dual eligibles in HCB settings. These estimates led the Lewin Group to conclude that nursing facility residents, assisted living and other residential care residents, and HCB waiver participants use a similar number of prescribed medications.

Table 1
Estimates of the Average Number of Prescribed Medications among Medicare Beneficiaries by Different Settings

Setting/Data Source	Year	Number of Scripts	
		Monthly	Annual
Nursing Facility - Tobias and Sey (Monthly)	2000	9.3	74.4
Assisted Living - Briesacher (Monthly)	1998	7.5	60.0
Other Residential Alternatives (Monthly)	2002	8-10	72.0
HCBS Waiver Participants			
MEPS (Annual)	2003	8.3	66.1
All Full Dual Eligibles			
CMS (Annual)	2006	4.8	38.1

[1] In 2009, personal needs allowances for dual eligibles receiving Medicaid long term care services in assisted living communities ranged from $30 a month in Missouri to $178 monthly in New York. Source: "State Medicaid Reimbursement Policies and Practices in Assisted Living," Robert Mollica, National Center for Assisted Living, September 2009, p. 144, available at www.ncal.org.

Nursing Facility Residents –Tobias and Sey found that the average nursing facility resident routinely takes 6.7 medications and 2.6 medications on an as needed basis or 9.3 on average total.[2] The Institutional Prescription Drug component of the 1998 Medicare Current Beneficiary Survey indicates that nursing home residents took 8.1 medications per month.[3]

Assisted Living – The Institutional Prescription Drug component of the 1998 Medicare Current Beneficiary Survey indicates that assisted living residents took 7.5 medications per month.[4]

Other Residential Alternatives – Residents in other residential alternatives use a similar number of prescriptions – about 8-10 prescriptions, according to recent studies.[5]

Medicaid HCB Services Waiver Participants – According to Medical Expenditure Panel Survey, HCB Waiver participants took a similar amount of medications as the rest of seniors - 66.1 annually or 8.3 per month. In a focus group of HCB Waiver administrators, one administer reported that most clients in the waiver program receive 5 to 10 medications per month.[6]

Support for Proposed Implementation Date

Since the inception of Medicare Part D, NCAL has lead a coalition of nearly 40 national organizations representing Medicare beneficiaries, health professionals, state officials, pharmacies, care providers, and other interests, urging Congress to support legislation that would eliminate Medicare Part D co-payments for all dual eligible residents of assisted living and residential care facilities and others receiving HCB services under Medicaid. The coalition was instrumental in having bills introduced in the last three sessions of Congress to eliminate Part D cost sharing for the entire dual eligible population that receives long term care and HCB services.

During the 111th Congress, Sen. Bill Nelson (D-FL) sponsored the Home and Community Services Copayment Equity Act of 2009 (S. 534) and Rep. Lloyd Doggett (D-TX) sponsored a companion bill, the Medicare Part D Home and Community Services Copayment Equity Act of 2009 (H.R. 1407). Unfortunately, in drafting Sec. 3309 of the ACA, Congress did not use the language of these bills, but rather picked up language from previous legislation that did not explicitly include part of the dual eligible population in community-based settings. AHCA/NCAL and other members of the coalition see Sec. 3309 as a partial solution and are now urging Congress and the Administration to finish the task of creating Part D cost sharing parity between dual eligibles in institutional and HCB settings.

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[2] Tobias, DE, Sey M. (2001). *General and psychotherapeutic medication use in 328 facilities: a year 2000 national survey.* Consultant Pharmacist 2001; 16(1):54-64.

[3] Briesacher B, Stuart B, Doshi J. (June 2002) *Medication Use by Medicare Beneficiaries Living in Nursing Homes and Assisted Living Facilities.* Report to US Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP). http://aspe.hhs.gov/daltcp/Reports/meduse.htm

[4] Briesacher B, Stuart B, Doshi J. (June 2002) *Medication Use by Medicare Beneficiaries Living in Nursing Homes and Assisted Living Facilities.* Report to US Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP). http://aspe.hhs.gov/daltcp/Reports/meduse.htm

[5] American Health Care Association "Medicare Part D Co-Payments Should Be Waived for Dual Eligible Residents of Assisted Living/Residential Care Facilities"

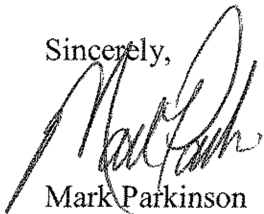
[6] Reester H., Tumlinson A., Blum J. (2005). *Dual Eligible Home and Community-Based Waiver Program Participants and the New Medicare Drug Benefit.* Kaiser Commission on Medicaid and Uninsured, October 2005.

Sec. 3309 eliminates cost sharing for full-benefit dual eligibles who receive HCB services under a waiver authorized under Sec. 1115 or subsection (c) or (d) of Sec. 1915 of the Act, or under a State Plan Amendment under Sec. 1915(i), or if such services are provided through enrollment in a Medicaid managed care organization with a contract under Sec. 1903(m) or 1932. AHCA/NCAL is concerned that the wording of Sec. 3309 may inadvertently omit parts of the HCB full-benefit dual eligible population, namely some dual eligibles who are not covered under Medicaid waivers but rather directly under Medicaid state plans. Several states, for example, provide Medicaid HCB services in assisted living settings without using a waiver.

As noted in the proposed rule, Sec. 3309 provides the Secretary with discretion regarding the effective date of the provision, with the stipulation that it shall be effective no earlier than Jan. 1, 2012. Because the provision lacks a definite implementation deadline, coalition members have concerns that co-payment relief for this vulnerable population might be delayed. We, therefore, are delighted that CMS proposes to implement Sec. 3309 as soon as possible. According to the proposed rule (p. 71204): "We (CMS) are proposing that this provision take effect January 1, 2012. We believe it is important to provide this benefit at the earliest possible date, since it will provide assistance to an estimated 600,000 beneficiaries a year. In proposing an effective date, we considered the administrative impact on States, and we believe that even the earliest possible effective date will provide States with adequate time for implementation."

In conclusion, AHCA/NCAL commends CMS for proposing the earliest possible date to implement Sec. 3309 and for its commitment to improving the care and bettering the lives of dual eligibles. We pledge to continue our partnership with CMS to work toward these goals and will assist in whatever way possible.

Sincerely,



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