CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

January 16, 2018

By electronic delivery to www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
PO Box 8013
Baltimore MD 21244-8013

Re: CMS-4182-P Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2019

California Health Advocates appreciates the opportunity to provide a response to the above-referenced Notice of Proposed Rulemaking (NPRM).

California Health Advocates (CHA), a non-profit organization founded in 1997, is the leading Medicare advocacy and educational voice for more than 5.6 million California Medicare beneficiaries.

We appreciate the opportunity to comment on the extensive changes proposed in this rulemaking. Our comments address both the general direction of the NPRM and some of the specific provisions that are most likely to affect the Medicare beneficiaries we serve.

Scope and Timing. The scope of the proposal raises concern. It proposes to introduce changes to the Medicare program that would allow plans to offer supplemental benefits for only specific groups of beneficiaries, offer segmented benefits, and give plans more leeway in designing Part C and D benefit packages. Further, both C and D plans are offered opportunities to limit mailings of information to beneficiaries, submit fewer documents to CMS for review, change formularies midyear, take longer to handle appeals, and make other changes that that could profoundly affect the lives of older adults and people with disabilities who rely on Medicare. Most of these changes are expected to be available to plans for the 2019 plan year, though details generally have not yet been offered for comment, much less finalized.

We believe that CMS is proposing to move too quickly on too many fronts all at once. With so many changes, it will be hard to evaluate which change is responsible for which outcome.

Implementing so many changes so fast to an already complex system also presents serious challenges to beneficiaries. In the past, beneficiaries have suffered real harm that was unanticipated when introducing big changes that have not been tested on a small scale and where the details had not been carefully worked out with input from all affected parties, including beneficiaries and their advocates.

Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA). As part of the implementation of CARA, CMS is proposing new regulations to address the appeal process for beneficiaries who would be subject to a Part D pharmacy "lock-in." We encourage CMS to make appeal processes regarding a Part D pharmacy lock-in as simple as possible for beneficiaries, to ensure that

those beneficiaries who need particular drugs can access them. We ask CMS to implement all of the protections of CARA, including automatic escalation for independent review.

Simplifying Beneficiary Enrollment Choices. Current proposals to add flexibility in plan design and administration will add complications for beneficiaries. CMS is proposing to eliminate the requirement that plan sponsors show a "meaningful difference" between plan offerings in the same market. The beneficiaries we work with already are overwhelmed and confused by the number and complexity of choices they have in Medicare and find it very difficult to compare their options. We oppose this change.

Currently Medicare beneficiaries are deluged with marketing material, telephone solicitations, media advertisement, etc., all of which cause unnecessary confusion, particularly when in certain counties they have over 100 Part C plan options. Showing a meaningful difference between plan choices would assist beneficiaries, their caregivers and SHIP counselors to identify the significant differences between one plan and another.

Beneficiaries need a simpler and more straightforward array of options, not more complexity. They need to be able to compare provider networks and services offered. The current Plan Finder, though helpful with drug choices, is not very useful for comparing Medicare Advantage plans. We ask that CMS maintain a "meaningful difference" requirement so that beneficiaries are not further confused. We also urge CMS to work on improving the Plan Finder. Our clients do not suffer from too few choices. They instead have the problem of too many choices and too few tools that let them make informed decisions about those choices.

Continuous Special Enrollment Period for Dual Eligibles. CMS is proposing to eliminate the continuous Special Enrollment Period for dual eligibles and beneficiaries who qualify for the Low Income Subsidy (LIS) and replace it with a complicated set of limited SEPs. Older adults and people with disabilities who use LIS do not have the financial resources to weather any disruption or denial of care. Our experience is that beneficiaries rarely use their continuous SEP but, when they do, they need it. We also like the current SEP for LIS beneficiaries because it is one of the few elements in Medicare that is simple and straightforward. We can explain it to our clients and we can help them use it if they make a mistake or if their needs change.

California dual eligible beneficiaries have very different needs depending on their health and their geographical location. Beneficiary access to providers, specialists and hospitals varies significantly from county to county – e.g. major urban vs small suburban or rural communities. Providers drop out of networks, formulary changes, changes due to moves related to affordable housing, beneficiary's health conditions – all contribute to the need for a continuous SEP.

We urge CMS to retain the continuous SEP for LIS beneficiaries.

Opt-out for electronic delivery of documents*.* CMS is proposing that the default method for delivery of the Evidence of Coverage (the Member Handbook) and the Summary of Benefits be electronic access through the plan's website. Beneficiaries would have to opt out of electronic delivery if they want a hard copy. This proposal would burden our clients, many of whom do not have easy access to electronic documents. Many older or impaired beneficiaries are unable to make use electronic of equipment or documents. We ask that electronic delivery of documents be "opt-in," rather "opt-out."

Of particular concern is the fact that thousands, if not millions of beneficiaries don't have access, or reliable access, to the Internet in California – both due to cost or geographical location, e.g. rural communities. SHIP counselors often report that beneficiaries want documents in writing, easy to understand MSNs, Member Handbooks, Explanation of Benefits (EOB), etc. They are not sufficiently savvy to negotiate electronic media. Default communication method should remain as paper, not electronic.

Language Access. We were pleased that CMS is proposing to extend its current document translation requirement to "communications" designated by CMS rather than limiting it to certain marketing documents. We ask that CMS adopt this change and, in implementation, expand the list of specific documents that are subject to translation rules. Currently, many important documents are not translated, such as notices that beneficiaries are being denied services or will be disenrolled for failure to pay premiums. We also ask that CMS change the current translation standard, which only covers languages spoken by five percent or more of the population in the service area. The current rule means that, except for a couple of small pockets, the only required language for translation is Spanish.

California has a high percentage of limited English proficiency Medicare beneficiaries. People whose primary language is Spanish, Russian, Vietnamese, Hmong, Farsi, Hindi, etc., have a very difficult time navigating the Medicare system without assistance. Personal experiences expressed to SHIP counselors include inability to understand documents, lack of knowledge about asking for materials in their language, or not having family member who can assist.

Part D Tiering Exceptions. CMS proposes to clarify requirements for how tiering exceptions are to be adjudicated and effectuated. We agree that beneficiaries currently have difficulty in understanding and using tiering exceptions, and we support efforts to simplify the process for beneficiaries. We also ask that CMS continue to do more to educate beneficiaries about the availability of the tiering exception and require plans to do more as well.

SHIP counselors report that Tier 4, 5, Specialty medications consistently require an exception or prior authorization. This causes delays in obtaining their medications, and if they do not receive the assistance from a willing pharmacist, doctor, family member, or SHIP counselor, they often give up and do not exercise their right to request an exception. In 2017 and 2018, SHIP counselors and beneficiaries reported a high number of formulary changes in plans which resulted in requiring a tier exception. Some drugs that were originally in a Tier 2 or 3 are now Tier 4 or higher, e.g. Lipitor.

Ombuds. Beneficiaries need help in navigating their benefits. We strongly urge CMS to expand and strengthen its Medicare Ombuds program. A broader Ombuds program would give beneficiaries needed assistance and also allow CMS to better identify systemic issues that are likely to arise as different benefit designs are implemented.

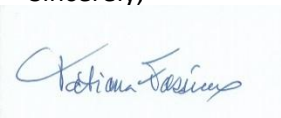
In California, the SHIP program known as Health Insurance Counseling & Advocacy Program (HICAP) has been very successful in assisting Medicare beneficiaries with their Part C or D issues. Evidence suggests that CSRs from 1-800 Medicare often give out incorrect information, and the Medicare Ombuds is rarely if ever contacted for assistance with navigating and using their benefits. Long Term Care Ombudsman volunteers are not trained to assist beneficiaries residing in Assisted Living or Long Term Care facilities, whether they are dual eligible in a demonstration program, PACE, or other setting. Consequently, the need to involve the local SHIP/HICAP is essential.

Oversight and Evaluation. Despite the very significant changes being proposed, the NPRM includes several provisions that would limit, rather than increase, the agency's oversight of plan performance. Oversight of plans is a core responsibility of CMS. It is an obligation that the agency owes to its beneficiaries, particularly in light of the proposals for increased flexibility and variety in plan design. We urge CMS to ensure that any changes be accompanied by rigorous, data-driven evaluation to determine which of the changes are actually resulting in improvements for beneficiaries.

In California, the Department of Managed Health Care (DMHC) and the Department of Insurance have been partners with the advocacy organizations to resolve Part C issues that are pertinent to their oversight. However, plan performance and data driven evaluation must remain a CMS obligation since federal law limits state enforcement of these activities.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at 916-231-5110.

Sincerely,



Tatiana Fassieux
Board Chair