



Multipurpose Senior Services Program Site Association
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January 12, 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

The California Multipurpose Senior Services Program Site Association (MSA) appreciates the opportunity to provide a response to the above-referenced Notice of Proposed Rulemaking (NPRM).

MSA is comprised of 38 sites that provide long term case management to frail and vulnerable seniors age 65 and older living in communities throughout the state who have significant health and cognitive impairments that would make them eligible for nursing home placement. The programs serve over 11,000 beneficiaries through a Medicaid 1915(c) waiver.

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 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, we have seen beneficiaries suffer 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.

The introduction of the Part D prescription plan caused many Medicare beneficiaries in our program into turmoil as well as those who were not prepared to provide information on the new initiative or the choices that were provided. Many found it difficult to get their prescriptions filled as a result of the confusion on the part of the beneficiaries as well as providers. This was an example of a program that was introduced with little preparation and created months of problems for all involved.

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 choices they have in Medicare and find it very difficult to compare their options. We oppose this change.

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 few tools to 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. 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 let alone the computer knowledge required to access. We ask that electronic delivery of documents be “opt-in,” rather “opt-out.”

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 small pockets, the only required language for translation is Spanish.

In a state as diverse as California, it is not uncommon to have beneficiaries from one site that speak a dozen or more different languages. Beneficiaries with visual impairments are also quite common.

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.

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.

As described above, the transition to Part D was difficult. If the ombuds program had not been a resource to the providers and beneficiaries, it would have been a lot worse.

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.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at 916-397-1509.

Sincerely,

Janet Heath
Executive Director
MSSP Site Association