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January 16, 2018

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-4182-P

P.O. Box 8013

Baltimore, MD 21244-8013

**RE: CMS-4182-P: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program**

Southwest Catholic Health Network appreciates the opportunity to comment on the proposed rule titled “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program”

(the “proposed rule”). Below are our comments for your consideration.

**Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions:** We support this proposed change, but ask that CMS reconsider the proposed special 6 month waiting period from the time CMS identifies a potentially at-risk beneficiary before discussions can begin regarding prescriber lock-in. When factoring in the case management review, prescriber outreach, and member notification this could potentially delay meaningful intervention to 8 months or more. This time period is too long to effect the necessary change, could contribute to addiction, and have detrimental outcomes.

**Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of**

**Coverage and Change of Coverage (§§ 422.66 and 422.68):** Our contract received CMS approval for Seamless Enrollment a couple years ago. We have enrolling dual eligible individuals under this process successfully since our implementation. We send the required advance member notifications and also conduct telephonic outreach to identified enrollees to help explain who and why they were seamlessly enrolled and explain their new Medicare plan coverage and help with questions. Our opt-out rate has been very low.

We disagree that CMS should limit approval issued to a specific timeframe (2-5 years); instead it is our opinion that consistent routine oversight and monitoring should be applied by the Health Plan, CMS, and the State Medicaid Agency when seamless enrollment approval is granted. As part of our monthly processes, we closely monitor the number of identified Medicare eligibles received on the monthly state reports. If there appear to be discrepancies we immediately notify our State Medicaid contact to investigate and inform our CMS Regional Office Plan Manager. We provide a monthly Seamless Enrollment Report to our CMS Regional Office Plan Manager and our State Medicaid contact. We conduct routine internal audits to ensure the process approved by CMS is being applied consistently. This type of monitoring and oversight should be conducted by any health plan who receives approval and the CMS RO should request and review monthly reports from approved health plans.

**Passive Enrollment Flexibilities To Protect Continuity of Integrated Care for Dually Eligible Beneficiaries (§ 422.60(g)):** We support this change because it will support promote alignment for dual eligible beneficiaries impacted by state re-procurement and/or D-SNP non-renewal.

**Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries (§ 423.38):** We disagree with this proposed change as written because the proposed change to the existing continuous SEP should be reconsidered due to the fact that dual eligible SNP beneficiaries are not a homogenous demographic and range from healthy low-income beneficiaries to those with multiple and complex medical conditions that require long-term care, as well as, those living with the complexities of serious mental illness. Many of the beneficiaries we serve are not only medically challenged, but economically, educationally, and linguistically disadvantaged, as well. Without the benefit of meeting with them in their own homes and experiencing first-hand the hardships they encounter, it is hard to overstate how vulnerable this can make them. As a result these vulnerable populations should be protected from a limited enrollment period where the increased pressure of using their one-time annual election period could be easily manipulated by someone who may not have their best interest in mind.

If the current continuous SEP is eliminated in favor of an abbreviated enrollment period, these vulnerable beneficiaries could be viewed as a commodity, exchanging a relationship building approach to that of a transaction. Furthermore, creating greater eligibility complexity increases the difficulty of understanding plan benefits and member responsibilities, thus disadvantaging them further and making them even more susceptible to marketing manipulation.

Enrolling in two separate organizations for their Medicaid and Medicare plan benefits disrupts the greater integration achieved when both are offered by a single organization. If a one-time annual SEP is mandated, it will be impossible for impacted beneficiaries to re-align their Medicare and Medicaid health plans until the next enrollment period. This unintended consequence will limit the coordination of care, case management, and integrated customer service which is what the new proposal is trying to prevent. Based on the information we’ve provided we ask that CMS reconsider this proposed rule as written and instead of limiting to a one-time annual SEP instead consider the following options:

* Consider continuing to allow a continuous SEP to allow for dual eligible beneficiaries to make changes to support Medicare and Medicaid plan alignment, or
* Allow for more than one Part D SEP per year but with lock-in period, taking into account other applicable SEP exceptions that could apply to a beneficiary such as an SEP due to making a permanent move, etc.

**Medicare Advantage and Part D Prescription Drug Program Quality Rating System:** We are in support of the longer lead time for changes to the Star Ratings system as the complex measurement periods of various measures coupled with the complexity of monitoring and improving ratings are made more difficult as measures are added and deleted from year to year. We suggest that CMS simplify the process by using the NCQA HEDIS National percentiles for the HEDIS measures. We also encourage CMS to allow reporting at the plan level instead of the PBP level.

**Changes to the Days’ Supply Required by the Part D Transition Process:** We support this proposed change, but recommend CMS provide clarification regarding the proposed rule of a “month’s supply” and how a “month’s supply” will be administered for unbreakable drug packages.

**Reducing the Burden of the Compliance Program Training Requirements (§§ 422.503 and 423.504):** We disagree with this proposed change. For years CMS has focused on the need for health plans and their contracted FDRs to use standardized Compliance training. Initially there were some challenges implementing this requirement, but overtime the challenges decreased and health plans and FDRs use the CMS Compliance training available to meet this annual requirement. Requiring the use of the CMS Compliance training available allows for consistent educational guidance and this training is not over burdensome. Additionally, CMS currently allows health plans and FDRs the flexibility to develop additional business specific compliance training that can be provided in addition to the CMS Compliance training to meet business training goals & objectives. Eliminating the CMS Compliance training requirement for FDRs will significantly increase health plan burden because it will require health plans to conduct an annual independent review of each FDRs Compliance training programs to validate if what they have developed aligns with CMS requirements and expectations. If it’s identified that FDR training developed does not comply with CMS expectations, it is highly anticipated that FDRs will dispute making any required revisions because they are not being held to the same CMS Compliance training requirements as the health plans. FDRs should be held to the same CMS Compliance training requirements as health plans. For this reason we ask that CMS reconsider their position regarding this proposed change.

**Revisions to Timing and Method of Disclosure Requirements (§§ 422.111 and 423.128):** We support continuing to require the annual ANOC by 9/30 and allowing the additional time for the new formulary and provider/pharmacy directories to be available and posted to plan website by 10/15. We do not support the EOC having to be available and posted by 10/15. As a contracted D-SNP, we have exercised the option to provide the EOC to our membership by the 12/31 deadline. Using this additional time for development has resulted in accurate EOC development and eliminated the need to have to mail errata notices. Due to the size and complexity of information that must be included in the EOC we encourage CMS to consider allowing all health plans additional time to develop and provide the EOC to help reduce errors.

As noted by CMS, the EOC is considered the contract between the Medicare beneficiary and the health plan. While it is true that beneficiaries may find the EOC overwhelming it does provide them with their plan guidelines, benefit coverage, roles and responsibilities and other important information. Eliminating the requirement for health plans to have to mail a hard copy EOC to enrollees except upon request is an attractive option, but from a compliance perspective it raises concerns regarding proper enrollee education about their plan benefit coverage and guidelines. It will make it challenging for health plans to support and justify appeal upholds and grievance outcomes when an enrollee states they never requested a copy of their EOC or reviewed it online therefore they were unaware of their plan benefit coverage or guidelines. We ask that CMS give these concerns consideration when developing the final rule.

**Revisions to §§ 422 and 423 Subpart V, Communication/Marketing Materials and Activities:** We support the changes as proposed.

**Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations (§§ 423.590 and 423.636):** We support the changes as proposed.

**Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE (§ 422.590):** While in theory this change sounds beneficial, beneficiaries have a right to be informed when the health plan has upheld their denial decision and is sending their appeal to the IRE for review and they have a right to receive IRE notice confirming receipt of their appeal for further review. For this reason we recommend CMS not adopt this change.

**Reduction of Past Performance Review Period for Applications Submitted by Current Medicare Contracting Organizations (§§ 422.502 and 423.503):** We support the changes as proposed.

**Preclusion List—Part D Provisions:** We support the changes as proposed.

**Preclusion List—Part C/Medicare Advantage:** We support the changes as proposed.

**Removal of Quality Improvement Project for Medicare Advantage Organizations (§ 422.152):** We support the changes as proposed.

**Changes to the Agent/Broker Requirements (§§ 422.2272(e) and 423.2272(e)):** We support the changes as proposed.

Our Pharmacy Benefits Manager is submitting separate comments for the other Part D proposed changes.

If you have any questions, please contact me at 909-792-3937 or [MaciasC1@aetna.com](mailto:MaciasC1@aetna.com).

Sincerely,

Christina Macias

Medicare Compliance Officer

Southwest Catholic Health Network d/b/a Mercy Care Advantage