January 16, 2018

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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**

AgeOptions appreciates the opportunity to provide a response to the above-referenced Notice of Proposed Rulemaking (NPRM). We are supporting the comments from Justice in Aging which offered the foundation for our own comments and identified direct experiences, and have asked fellow Immediate Response Committee members for the American Society on Aging Policy Committee to consider supporting the basic Justice in Aging comments as offered here,.

AgeOptions is a nonprofit organization connecting older adults and those who care for them with resources and service options so they can live their lives to the fullest. Since 1974, our mission has been to sustain and promote independence for older persons in their own homes and communities. As the Area Agency on Aging of suburban Cook County, Illinois, we advocate, plan, coordinate and fund services for older adults.

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, 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.

***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 (people on Medicare and Medicaid) 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.

People who qualify as dual eligibles or for LIS have lower incomes, and the continuous SEP protects them from extra financial burdens. AgeOptions has worked with clients who used the continuous SEP when their doctors prescribe them a new drug that is not on their current plans formulary. This SEP allowed them to find a Part D plan that would cover all of their drugs. Our clients have also not realize their Part D plan premium would rise above the LIS benchmark for the next year and that they would be responsible for the premium above that benchmark. They have had to change Part D plans after the annual open enrollment to avoid paying extra for their premium. The continuous SEP provides very low income beneficiaries the opportunity to use their limited resources to cover other medical needs or necessities.

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. 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.

***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.

***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 closing, we urge CMS not to implement changes that confuse beneficiaries or limit itself from offering simple, consistent, fair and caring support for beneficiaries.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at [jon.lavin@ageoptions.org](mailto:jon.lavin@ageoptions.org).

Sincerely,

Jonathan Lavin

Chief Executive Officer

AgeOptions