Comments Received on Integrated Denial Notice (CMS–10003) – 60 day comment period

Document (specify notice, instructions, burden estimates)	Page #	Comment (commenter and summary of comment)	CMS Response
Instructions	1	PrimeWest Health, Rebecca Fuller <u>Why Did we deny your request (instructions):</u> PrimeWest Health respectfully does not agree with the instructions to send a denial notice when Medicare doesn't cover something but Medicaid would. Sending this denial notice when a service is, in fact, going to be covered under the Medicaid benefit would be confusing to members and cause unnecessary worry for them. Members should not have to worry whether Medicaid or Medicare is covering their services. That is actually the point of a dual-eligible plan. Also, such a change would add additional administrative burdens for plans.	1. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to cause member confusion and increase additional administrative burden to plans. Therefore, we have made revisions to the instructions. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.
Notice, Instructions		SNP Alliance, Pamela Parker <u>Questions Related to the State Medicaid Agency Appeal Rights and Notices</u> 1. When the plan determines that the item or service is to be denied under both Medicare and Medicaid, plans are instructed to include the appropriate Medicaid appeal rights and instructions on how a member may ask for a Medicaid State Fair Hearing. When the plan issues the IDN in this scenario, it is assumed that the plan would not issue a Medicaid Notice of Action (NOA) and Medicaid State Fair Hearing form to the member, in addition to the IDN. For the denial scenario noted above, is there an assumption by CMS that plans should obtain an approval from each of their State Medicaid partners for issuing the IDN to the member in lieu of	1. The comments related to obtaining approval from each state for issuing the IDN in lieu of the state's required notices is outside the scope of this PRA package. 2. Again, the comments related to each state's required notices and how to use with the IDN is outside the scope of this PRA package. 3. Because this comment is related to coordination between CMS and state Medicaid agencies, it is also

		the state's required NOA and Medicaid State Fair Hearing forms? 2. If the State Medicaid agency does not approve the plan's use of the IDN in lieu of issuing the NOA and State Fair Hearing Form, the plan would not include the Medicaid appeal rights and/or instructions for requesting a State Fair Hearing as part of IDN verbiage. Will the plan be cited by CMS for noncompliance by not adhering to the CMS IDN Form Instructions? 3. If the State Medicaid agency approves the use of the IDN to include the Medicaid appeal rights, butrequires the plan to include the State Fair Hearing form with the IDN, the IDN notice and form may result in a document that could potentially be 6 (six) or more pages long. With the knowledge that a disproportionate share of the dually eligible member population are frail, have significant cognitive impairments, or disabilities such as mental illness or intellectual and development disabilities, receiving this lengthy notice from their plan may be intimidating and confusing, which may result in the member not reading the notice at all. This poses a concern since plans are aware of the importance of their members understanding this important communication regarding denial of requested medical services. We request that CMS coordinate with Medicaid at CMS and state levels to provide answers to these questions and to develop coordinated Medicare Medicaid policy that simplifies and streamlines these materials to reduce the burden on beneficiaries. <u>4. Dramatic Expansion of Scope of Use in Issuance of Medicare Denials for All Covered Medicaid Services</u> We are very concerned about new language that appears in the instructions under the section titled "Why Did We Deny Your Request?" which appears to greatly expand the scope of use of this document and require its issuance whenever a Medicaid service is covered in an integrated plan. This instruction could result in millions of new duplicative and confusing notices to beneficiaries. We understand that under this instruction, the IDN notice would continue to be sent for any Medicare covered service that is denied, and that the language would allow for explanation when that service can be provided under Medicaid. In these situations, there is overlap between the same Medicare	outside of the scope of this PRA package. 4. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to increase member confusion, result in duplicative notices, increase administrative burden for plans, and increase the number of appeals. Therefore, we have made appropriate revisions the instructions. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.

		and Medicaid services where Medicaid may have different coverage criteria and thus can provide essentially the same service under Medicaid coverage criteria. Used in this manner, this notice continues to serve an appropriate and important function and we support its continued use. However, if our understanding is correct, we are very concerned that these instructions go much further and represent a large policy change for integrated programs, greatly expanding the scope and use of this notice and dramatically increasing the administrative burden on enrollees as well as plans and states involved in offering these products. Taken literally, and based on information from parties who have had discussions with CMS on this topic, the notice instructions appear to assume that all requests for service to the integrated plan are treated as if they are requests for Medicare services, even if those services are exclusively Medicaid-covered services and would never be covered by Medicare. Currently, integrated plans would not send a Medicare denial notice for service requests covered only under their state Medicaid contract and use of this notice in this manner ignores the fact that a plan has a separate contract with the state to provide a different set of services under Medicaid. The proposed change does not support current person-centeredness integration efforts already underway. Beneficiaries receiving a notice entitled Notice of Denial of Medical Coverage are likely to be confused and/or upset by the title alone. Use of such a notice is helpful when an actual Medicare service is being denied, because it can assure the member that services will still be covered under Medicaid. But expanding the use of such a notice to Medicaid services not covered by Medicare will be unnecessarily confusing to members. Members may be even more confused about why they are getting a Medicare Denial notice for Medicaid only services actually being provided by the plan, thus resulting in a significant amount of unnecessary calls to Medicare, State Agencies and providers. If these instructions are to be taken literally, it will mean a huge increase in the number of denials sent to beneficiaries by integrated plans because Medicaid-only covered services are often high frequency services such as personal care, transportation and interpreter	

		services resulting in millions and millions of additional notices. States already have their own requirements for notices that must be sent when Medicaid services are approved or denied so these additional Medicare notices indicating that services provided under Medicaid are covered will be duplicative. All of these additional notices could then generate additional Medicare appeals from members who are confused because they are receiving a denial from Medicare and think that that something has gone wrong and that Medicare should have covered the Medicaid service. This could result in other potential inadvertent consequences for plans such as increased appeals volumes and impacts on Star Ratings. SNP Alliance member plans and states with which they contract who are aware of this issue say that if the interpretation that they have discussed with CMS prevails, complying with this new instruction will also require significant changes in state contracts with integrated plans and state policy as well as systems programming for generation of notices. Some states and plans already have mechanisms in place to coordinate their current Medicaid notice requirements along with current Medicare requirements using state and plan electronic systems to collect information on both sets of services. The change in requirements under this document would require programming changes in those systems. We believe the burden time and cost estimates provided by CMS for this provision for plans, states and beneficiaries are vastly underrepresented in the supporting documentation because this requirement is likely to generate significant additional administrative paper work, systems costs and millions of new denial notices most of which will be duplicative (e.g., a Medicare denial and a Medicaid approval – for the same service). We are further concerned that such a large policy change is being implemented through a CMS notice process related to the Paperwork Reduction Act, which is not where many stakeholders would expect to find a change of this magnitude. We strongly request that CMS clarify these instructions to apply only where there is a clearly overlapping	

		service between Medicare and Medicaid, and to exclude services that are covered only by Medicaid.	
Notice	Pages 1, 3	Emblem Health, Lauren Parrish 1. <u>Appeal section:</u> Consider adding "calendar" to the timeframe of 60 days..."60 calendar days"; this would help to provide clarification to the Medicare members that they have 60 calendar days from the IDN letter date to initiate an appeal. 2. <u>Step 2 for a Standard Appeal section:</u> Consider addition instructions recommending health plans to include a "delivery in-person address" when the "mail to address" is a P.O. Box; the "delivery in-person address" option would ensure Medicare members' standard appeals are received in a timely manner (versus sending the appeal mail envelope to a P.O. Box). 3. <u>Why did we deny your request Section</u>: under specific rationale, add *(in easily understandable language)* 4. <u>Page 3 - Step 2</u>: add TTY.	1. CMS has determined the current language is appropriate. 2. Per commenter's suggestion, we have added a section for "In-person delivery address" in curly brackets to be used, if applicable. 3. CMS has added additional language in "Section Titled: Why did we deny your request?" to clarify what must be included in denial rationale. 4. CMS accepted the comment to add TTY to applicable sections of the notice.
Notice, Instructions		Anthem, Inc., Leah Hirsch 1. <u>You have the right to appeal our decision section:</u> CMS has inserted the following language: *"State Fair Hearing: Ask for a State Fair Hearing within ( ) days of the date of this notice. You have up to ( ) days if you have a good reason for being late. See page (insert page number) of this notice for information about how to ask for a State Fair Hearing."* Given that the generation of notices is an automated process for most plans and the notices generated for each member may vary in length based on the number of procedure codes/descriptions for each claim, the system has no way of tracking/determining in each case which page of the denial notice for each member has the information pertaining to the State Fair Hearing, As a result, complying with this requirement will be very problematic for plans. We recommend that quoted text in comment section be replaced by the following language, since information regarding the State Fair Hearing may	1. CMS has accepted this suggestion and replaced the reference to a page number with a reference to the name of the applicable section. 2. CMs has included language in the notice instructions that plans may remove the fast appeals section if the notice is for a payment denial. 3. CMS did not accept this suggestion. Language was inserted to remain compliant with request for alternative format requirements of Section 504 of the Rehabilitation Act. 4. Issue 1: CMS has accepted this comment and has removed the language "If

		appear on a different page for each member depending on the number of procedures. *"**State Fair Hearing**: Ask for a State Fair Hearing within ( ) days of the date of this notice. You have up to ( ) days if you have a good reason for being late. See section within letter titled How to ask for a State Fair Hearing of this notice for information about how to ask for a State Fair Hearing."* 2. <u>Section, When to ask for an appeal</u>: The narrative does not provide enough information to let members know that they are not entitled to an expedited appeal when a request for payment of service is already provided. In order to avoid member abrasion/complaints, we recommend that CMS amend the language to indicate the following instead in the "How to ask for an Appeal" section of the notice. *Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one). Please note that if request for payment of a service has already been provided, your claim cannot be reviewed as an expedited reconsideration.* 3. <u>Added 504 language</u>: Directing members to 1--800-MEDICARE or to email. AltFormat@cms.hhs.gov when the correspondence was generated by the plan can cause abrasion to members, since CMS would not have the information related to the claim to properly discuss with members. We recommend that rather than directing members to 1--800-MEDICARE or to email AltFormat@cms.hhs.gov, CMS should add the following language disclaimer already provided in the Medicare Marketing Guidelines that speaks to this. *" This information is available for free in other languages. Please call our customer service number at [insert customer service and TTY numbers, and hours of operation]."* 4. <u>Notice delivered in Spanish:</u> The instructions include the following: *"When the Spanish-language version of this notice is used, the Medicare health plan must make insertions on*	this is impossible" in the instructions. Issue 2: CMS has not accepted this suggestion. Current regulations require that written notification of adverse initial determinations must be readable and understandable to the enrollee. This would include any information in free text fields, including the denial rationale. 5. CMS acknowledges this comment and has made revisions to the instructions under the "Why did we deny your request" section. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.

		the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the enrollee comprehends the content of the notice." Issue 1: The language within the same narrative appears to be contradictory "must make"/ "if this is impossible." Recommendation 1: We recommend that the instructions be changed to the following instead*:" When the Spanish-language version of this notice is used, the Medicare health plan should make insertions on the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the enrollee comprehends the content of the notice.* Issue 2: This can be a massive undertaking when you Consider the share number of procedure codes (CPTs, HCPCs and Revenue codes) that are provided for denied services on claims, the CARC/RARC codes & which provide descriptions for the denial, and the Claim Adjustment Reason Code (CARC) – 355 codes Remittance Adjustment Reason Code (RARC) – 1,041 codes. Recommendation 2: As an alternative to CMS' proposal about making insertions in Spanish on the notice, we recommend that plans be allowed to plans insert the following alternative language disclaimer: *This information is available for free in other languages. Please contact Customer Service at [insert customer service and TTY numbers, and hours of operation; and insert as applicable "Customer Service also has free language interpreter services available for non-English speakers."]* 5. <u>Why did we deny your request section:</u> The instructions state, *"For plans that manage both Medicare and Medicaid benefits (e.g., integrated Dual Special Needs Plans) --If a service/item is denied under Medicare but can be covered under Medicaid, the free text field should contain an explanation that the service/item will be covered under the enrollee's Medicaid benefits (in addition to the required explanation related to the Medicare denial)."*	

		The suggestion to add an explanation that the service can be covered by Medicaid may be premature and inaccurate since given the timing of the back-end process, plans are not sure if the issue identified/highlighted will be covered by Medicaid. We recommend that CMS revise the instructions to indicate the following instead. *[Medicare doesn't cover the denied medical service(s) as indicated above. Although we have denied this service(s) under Medicare benefits, because you have Medicaid coverage with us, this service(s) may be covered under Medicaid. And processed under your Medicaid health benefits.]*	
Instructions	1	Minnesota Dept. of Human Services, Gretchen Ulbee Why did we deny your request section: The revised instructions appear to require Medicare Advantage health plans that have an arrangement with the state to cover Medicaid services to issue Medicare denial notice to beneficiaries who will receive the covered service from the same plan under Medicaid. Such notices will only cause confusion and uncertainty. We are concerned because these new instructions imply that a notice needs to be sent by the health plan every time a service/item is covered by Medicaid and not Medicare. Minnesota health plans participating in our Medicare-Medicaid demonstration issue only a single notice of denial and issue denials only when the health plan will not provide the service. This process has worked very well to assist beneficiaries to get the actionable information they need if they will not be receiving a service. This will result in an avalanche of confusing and unhelpful mail for beneficiaries. When Minnesota created MSHO, we worked with the health plans to create and implement an integrated benefit determination process. The health plan would first determine if Medicare would cover the service and then if Medicaid would cover the service. A denial notice would only be issued to the member if the plan was denying or not paying for a service under either Medicare or Medicaid. It was determined that to send a Medicare denial notice when in fact the plan would be covering the service under Medicaid would be confusing to the member as there was no action the member needed to take. No appeal was necessary as the member had already received authorization for the	1. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to cause member confusion. Therefore, we have made appropriate revisions the instructions. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.

		service or the service already provided was paid for by the health plan. The new instructions to this notice seems to ignore the fact the state has certain requirements regarding the authorization and denial of these services including what notices are to be sent and when. When the IDN was initially created and issued, Medicaid services were taken into account and the process of issuing a single notice only when the health plan is not providing the service regardless of Medicare or Medicaid has worked very well. There are cases of overlap in some services such as skilled nursing and if the service is in fact moving from Medicare covered to Medicaid covered, a notice is to be issued as the service is a different level of service. We have been able to work with our health plans to assure that in these instances, appropriate notices are issued. If implemented as they appear, these instructions would result in possibly millions of new confusing and duplicative notices to members. According to these new instructions, the health plan would also be required to send the IDN notifying the enrollee that the services were denied under Medicare. This second notice serves no purpose except to confuse the member regarding whether services that were authorized will be covered. The burden of time and cost estimates that CMS provided for this provision for plans, states and members are vastly underrepresented in the documentation. It will result in development of new processes with attached systems costs, extreme increase in paperwork, an increase in time spent answering confused member's calls because of receiving notices that require no action on behalf of the member but imply a negative action on behalf of the health plan and millions of new notices being issued. Such a far-reaching policy change should not be implied by adding unclear instructions to a form. Please clarify that these instructions do not apply to Medicaid-only services that would never be covered under Medicare. The proposed instructions should be revised to apply only when there is a clear overlap of Medicare and Medicaid services such as skilled nursing. No Medicare denials should be issued for any services clearly covered only by Medicaid such as personal care attendant and	

		Section 1915(c) home and community-based waiver services.	
Notice, Instructions		Justice in Aging, Georgia Burke <u>Form Instructions for the Notice of Denial of Medical Coverage:</u> <u>1. Why did we deny your request?</u> We are concerned that a portion of this section creates confusion and alarm and does not serve a regulatory purpose. The section instructs plans that manage both Medicare and Medicaid benefits to send a denial notice even when the plan has approved the service as a Medicaid benefit. A beneficiary who receives a denial notice with a bold "Notice of Denial of Medical Coverage," heading, along with appeal instructions, is unlikely to understand the service is authorized. At the very least, the notice is likely to prompt an unnecessary call to the plan to get clarification. From a beneficiary's point of view, there is no purpose to be served by getting the notice. The beneficiary will get the service and will get it through the plan. Moreover, there is no regulation requiring a plan to send a denial notice when the plan has actually authorized the service. The most directly relevant regulatory section, 42 CFR 422.568, requires a notice if an organization "decides to deny service or payment in whole or in part . . ." but does not require a notice when, in fact, a service request has been fully approved. This requirement runs counter to the goal of integrating Medicare and Medicaid care and services. It fragments the beneficiary experience, causing confusion and unnecessary alarm. We ask that it be removed from the instructions. If, in fact, there are situations where approval of a service under Medicaid, though constituting full approval of the service requested, would in some way disadvantage the beneficiary compared to approval of the service under Medicare, those situations raise serious questions about whether D-SNPs are functioning as envisioned and as promoted by the plans. D-SNP members are supposed to be spared the complexities of navigating the intersection of Medicare and Medicaid benefits.	1. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to cause member confusion and we have made appropriate revisions the instructions. However, CMS does not believe an additional notice should be created. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued. 2. Any translated version of standardized notices must be OMB-approved. At this time, CMS has only created Spanish-language version of CMS-10003-NDMCP that is OMB approved. 3. CMS believes the free text fields are an appropriate place for health plans to insert the date services will end, therefore, we are not making changes based on this suggestion. 4. We did not accept the commenter's suggestion to change the section "How to keep your services while we review your case". The current language in this section includes important information about appeal rights that apply to both

		We urge CMS to look to structural remedies to those situations beyond what could be achieved by individual appeals. If such cases exist and until they are remedied globally, then a different notice should be designed for those, hopefully rare, circumstances. The notice should have a different heading and different leading sentence, both making it clear that the beneficiary can get the services requested. Plans should be required to include a specific explanation in the notice of why the beneficiary might be disadvantaged by the denial of Medicare coverage for the service. Without some guideposts, beneficiaries would have no way to understand what they might be losing even though they are receiving approval for all they have requested and would have no reasonable basis for deciding whether to pursue a Medicare appeal. <u>2. Translations and Multi-language inserts</u> We do not see instructions about language or disability notices, though there is reference to a Spanish version of the notice. We ask that the instructions require that plans: - Provide a translated copy of this notice to any plan member speaking a language that meets the threshold set by 42 CFR 422.2264(e) for marketing documents and, for individuals in plans that manage both their Medicare and Medicaid benefits, in any additional language that meets a different threshold set by the relevant state Medicaid agency. - Include a multi-language insert in all languages in the current Medicare insert, (see Medicare Marketing Guidelines, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2016-Medicare-Marketing-Guidelines-Updated.pdf at 30.5.1) and, for individuals in plans that manage both their Medicare and Medicaid benefits, in any additional languages that may be required by the relevant state Medicaid agency for Medicaid communications. We suggest the following text: *"We have free interpreter services to answer any questions you may have about this letter. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service."* Note that this would require only a slight change of one phrase in the current multi-language insert already included with marketing materials.	plan appeals and state fair hearings. 5. CMS believes this information is appropriately placed in the sections titled "How to ask for an appeal with {Health plan name} and "How to ask for a Medicaid State Fair Hearing" on page 3 of the notice. 6. Because this comment is related to coordination between CMS and each state Medicaid agency, it is outside of the scope of this PRA package. 7. Use of CMS-10003 extends to plans outside of the financial alignment demonstration. The enrollee's first point of contact should be the health plan itself. CMS will maintain the order of the phone numbers listed in the "Get more help & information" section as well as keep the Elder Health Locator contact information, which can assisting with finding additional assistance to beneficiaries with disabilities within their community. CMS has added a bracketed section for state or local aging/disability resources contact information, where SHIP contact information can be inserted. 8. CMS has added language on page 4 of the denial notice that states beneficiaries can request this publication in an alternate format. 9. The IDN is an OMB approved form and can only be modified in the free-text

		3. Your Request was denied. We suggest including a statement explaining when the denial will be effective. In New York's Fully Integrated Dual Advantage (FIDA) program, the Coverage Determination Notice (CDN) opens with: 1) Your Services were (denied) and you can appeal this decision. 2) The decision will take effect on: <effective date>. We suggest replicating the New York format in the IDN. 4. How to keep your services while we review your case: This section should only be included in the notice when the denial actually involves stopping, reducing or suspending a service. It is confusing to include it in other cases. The wording should change from "If we're stopping . . ." to "Because we're stopping . . ." This section should be inserted as a text box or highlighted. 5. You have a right to appeal your decision. We suggest including the phone number for the plan, the State Fair Hearing (SFH) office and the inclusion of an e-mail address where the individual can send the appeal to the plan for both the standard and fast appeal. 6.How to ask for Medicaid State Hearing: In states where individuals can request a SFH simultaneously or before a plan review, it would be much less confusing if the individual has the option of creating one appeal request and submitting it to one address. The beneficiary can tell the plan which appeal route or routes the beneficiary wishes to follow. Having a form for this purpose attached to the notice would facilitate this process. Requiring the individual to create two separate documents and submit them to two separate addresses is not an integrated process. 7. Get help & more information section When this notice is used by plans in the financial alignment demonstration, the first phone number and website listed should be the State Dual Eligible Demonstration Ombudsman Program should be the first contact listed after the plan itself. We also suggest removing the information for the Elder Care Locator, as	fields, as appropriate. The plan cannot include additional forms with the IDN.

		that contact is not appropriate or particularly helpful for appeals assistance, and substituting the number for the SHIP program in the plan's service area. <u>8. Notice of availability in other formats and of languages services</u> A notice should appear prominently on the letter stating that the recipient can request the notice in other formats such as Braille or large print. As we stated above, we also request the inclusion of a multi-language insert announcing the availability of interpreter assistance. If the insert cannot be immediately required, we ask at a minimum that there be a notice in English on the letter stating that interpreter assistance is available. <u>9. Appeal Form</u> We strongly recommend requiring plans to enclose an appeal form in each IDN. Beneficiaries should be encouraged, but not required, to use the form for the appeal. Having a form with boxes to check and blanks to fill greatly simplifies the start of an appeal for the beneficiary and also simplifies administration of appeals for the plan. It is much less intimidating, particularly for low literacy, limited-English proficient beneficiaries, than having to draft an appeal request from scratch. In addition to including the paper form, the plan should make the form available on its website with an e-mail address for submission. The form should allow for a State Fair Hearing option, if applicable, and have a box to request aid paid pending. The New York FIDA Appeal Request Form is a good model. Note especially that the New York form has boxes to request interpreter or disability assistance.	
Instructions	<u>1</u>	PRIDE-CHCS (Promoting Integrated Care for Dual Eligibles-Center for Health Care Strategies), Brianna Ensslin <u>Why did we deny your request? section:</u> PRIDE health plans support use of the IDN and do not have concerns about the form itself; however, we are concerned about new language that appears in the instructions for the section entitled why did we deny your request? The following outlines the PRIDE plans' concerns regarding the proposed change, and offers a question for CMS' consideration. The proposed new required text will result in:	1. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to cause member confusion and increase administrative burdens for plans-including increased call volume and mailing costs. Therefore, we have made appropriate

		1. Member confusion and unnecessary appeals. Required text would note a service is not covered here (under Medicare), but is covered there (under Medicaid), and the very next section provides information on appeals. There are several issues with this. The new instructions seem to assume that all requests for service are treated as requests for Medicare services, even if those services are exclusively Medicaid-covered services (such as non-emergency transportation, home and community-based services or personal care assistance) and would never be covered by Medicare. We believe this is "Medicare-centric" and wonder why this is necessary in the context of an integrated denial notice. If a service is covered under Medicaid, there is no reason to appeal. We anticipate an increase in unnecessary appeals filings, along with increased administrative costs. The proposed changes do not take into account the fact that many plans have a separate contract with the state to provide a different set of services under Medicaid. 2. Significant administrative burden to health plans that must update programming in systems to accommodate confusing text. 3. Increased mailing costs to send denials that are not needed because services are Medicaid covered. 4. Increased call volume to customer service centers, and subsequent challenges explaining why a member received a denial notice, when services can actually be provided/charges will be paid. Specific to dental services, because the majority of dental services are only covered under Medicaid, full dual eligibles will receive a denial notice for almost all of their dental services. Again, this will result in confusion and increased administrative costs. Currently, Medicaid only services (personal care assistants, private duty nursing, Elderly Waiver services, nursing facility services, dental, vision, transportation, certain mental health services (residential treatment), and home care therapies) are not reported to CMS. However, if health plans start issuing the CMS-10003 to explain why a service was approved as a state benefit, is the expectation that plans would then begin reporting on all services?	revisions the instructions. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.

		We encourage CMS to reconsider requiring the new language for the reasons noted.	
Notice	2,4	UnitedHealthcare, Shannon Schuster 1. Important Information About Your Appeal Rights UHC has concerns regarding appeal rights within the Integrated Denial Notice (IDN). The Standard Appeal section states "We'll give you a written decision on a standard appeal within 30 days [Insert timeframe for standard internal plan Medicaid appeals, if different] after we get your appeal." Later, the Fast Appeal section states both "...by waiting up to 30 days for a decision" and "If we don't give you a fast appeal, we'll give you a decision within 30 days." UHC believes that the bracketed statement of "[Insert timeframe for standard internal plan Medicaid appeals, if different]" should be added to both instances under the Fast Appeal section to ensure that this timeframe is consistent with the plan Medicaid appeals timeframe. 2. Additionally, UHC asks that CMS provide detailed versioning instructions between the pre- and post-appeal language. For example, there is a post-service version of the IDN that is sent to members when payment has been denied, which means that the services have been rendered. Therefore, the pre-service appeal language regarding the 30 day timeframe should not be included as it does not apply. We believe that the post-service IDNs should contain only the 60 day timetable language. Furthermore, any reference to "Fast Appeal" should be deleted for the post-service version of the IDN. 3. Alternate Formats UHC has concerns with CMS' statement regarding the request of alternative formats. The IDN currently states "To request this publication in an alternative format, please call 1-800- MEDICARE or email: AltFormat@cms.hhs.gov." We do not believe that contacting CMS for an alternative format is appropriate in this case. We believe that the applicable health plan should be contacted when requesting an alternative format of any document.	1. CMS believes the language is in the appropriate sections of the notice. 2. CMS agrees and has included language in the notice instructions that plans may remove the fast appeals section if the notice is for a payment denial. 3. CMS has inserted this language to remain compliant with request for alternative format requirements of Section 504 of the Rehabilitation Act.
Notice, Instructions		Medicare Rights Center, Casey Schwarz 1. Provide additional guidance on the 'free text' denial reasons section: We continue to encourage	1. CMS agrees and has provided additional clarification in the notice

		CMS to develop model language for the 'free text' portion of the denial notice for some of the more common reasons for a denial, like out-of-network services, and to review randomly selected denial notices to ensure that the 'free text' sections are clear, readable, and accurate. 2. Require more translation and multi-language inserts: We strongly support the requirement in the Notice Instructions that plans translate the 'free text' portions of the notice if the notice is delivered in Spanish. On translation, we urge CMS to go further and require that plans provide denial notices in the predominately spoken languages of their service areas. CMS should also require the inclusion of a multi-language insert with information about translation services for other languages. 3. Why did we deny your request section: First, we are pleased that the notice affirms that dually eligible beneficiaries must receive notice of the denial of their service under Medicare, even if the plan will pay benefits under Medicaid. We are concerned, however, that simply including this information in the section titled "Why we denied your request" is insufficient and may be confusing. We suggest that, in such situations, the headings be changed to reflect that the request is denied under Medicare but covered under the Medicaid benefit. In addition, we suggest adding language that makes clear to the beneficiary that while Medicaid will pay for the given service or treatment, the beneficiary has the right to appeal the decision that Medicare will no longer pay. We suggest including a specific explanation of this in the form instructions, rather than allowing plans to craft their own language in the 'free text' section. 4. "You have the right to appeal our decision," section: We strongly support the requirement to include accurate and appropriate information about State Medicaid fair hearing rights and Medicaid Managed Care appeal timelines where the denial includes Medicaid benefits. The plan—not the beneficiary—should be responsible for identifying which services are covered under which programs and should accurately and reliably direct the beneficiary to the correct appeals framework. 5. Section titled "Plan Appeal," We also suggest that the content in the "plan appeal" section parallel	instructions regarding what appropriate denial rationale must include. 2. Any translated version of standardized notices must be OMB-approved. At this time, CMS has only created Spanish-language version of CMS-10003-NDMCP that is OMB approved. 3. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to cause member confusion. CMS has included sample language for plans within the instructions and have also made appropriate revisions the instructions. In addition, the instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued. 4. CMS agrees and thanks you for your comment. 5. CMS accepts this suggestion and has inserted language that refers to the appropriate section on how to ask for an appeal. 6. Language is included that instructs plans to insert "State Fair Hearing", if applicable. CMS will keep the current sub-heading. 7. CMS does not believe that within the context of this

		the language included in the section titled, "State Fair Hearing." The section on fair hearings ends with "see page {xx} for information about how to file…," and we suggest adding the same language "see page {xx}…" at the end of the section on plan appeals. 6. In addition, we recommend that the sub-heading "How to keep your services while we review your case" include reference to the fair hearing so that it is clear to the beneficiary that the review only takes place with a fair hearing. A suggested rewrite of this heading could read, "How to keep your services during your appeal and/or fair hearing." 7. Section titled, "If you want someone else to act for you": We suggest that the heading more clearly indicate that someone else may represent you during your appeal and that within the paragraph the representation be expressly linked to the purpose of the appeal. A suggested rewrite of this title could read," If you want someone else to represent you during your appeal." 8. Section titled "Important Information About Your Appeal Rights": While we strongly support including information about fair hearing rights, the inclusion of this information makes the heading "there are two types of appeals" somewhat confusing for consumers. We encourage CMS to consider changing this language to "There are two timelines for plan appeals" or "You can ask us for a Standard or Fast Appeal". 9. Section titled, "How to ask for a Medicaid State Fair Hearing" We recommend that this section restate the information about aid continuing and the timeline in order to receive aid continuing.	notice there are any implied circumstances when a representative could act for a beneficiary outside of an appeal. CMS does not agree that this section needs further clarification. 8. CMS believes the current language in the heading "There are two types of appeals with {health plan}" appropriately identifies the two types are for a plan level appeal. 9. CMS believes language in the "You have the right to appeal our decision" section is appropriate for information regarding continuing services and CMS does not believe it should be included in multiple sections.
Notice	1-2	Center for Medicare Advocacy, Mary Ashkar 1. Your request was denied: Recommended change-When a Part C Medicare health plan decides to discontinue or reduce a previously authorized ongoing course of treatment the NDMPC should give the effective date coverage will end. Instructions should require that the last date of coverage or discharge date be listed. Rationale for recommended change: This change to the NDMPC would make it consistent with the	1. CMS believes the free text fields are an appropriate place for health plans to insert the date services will end, therefore, we are not making changes based on this suggestion. 2. CMS believes adding a placeholder for a deadline date could result in plans to making unnecessary system changes to accommodate

		Notice of Medicare Non-Coverage which gives the effective date coverage of current services will end. 2. <u>You have the right to appeal our decision:</u> · Recommended change #1-The revised NDMPC should include the date by which an appeal must be made. For example, *"Ask {health plan name} for an appeal within 60 days [Insert State Medicaid timeframe for internal plan appeals, if different] of the date of this notice. We must receive your appeal by: [Insert date when an appeal must be received]."* Rationale for recommended change #1: The Medicare Summary Notice (MSN) used for those who are in the traditional Medicare program includes a date in a box when an appeal must be received. Although the appeal tracks for traditional Medicare and Medicare Part C differ, the MSN serves the same purpose as the NDMPC, which is to give Medicare beneficiaries information in a meaningful and understandable way. People who are receiving a NDMPC may be in a health care crisis and including this information, in the same way as the MSN, ensures that there is no misunderstanding regarding the deadline for an appeal. 3. Recommended change #2: The NDMPC states that "[w]e can give you more time if you have a good reason for missing the deadline." This language is misleading. The NDMPC should be revised to state: "It is important that you appeal the decision within the 60-day period. If, however, you miss the 60-day period in which to file an appeal you may request an extension of the timeframe. The request for reconsideration and the request for an extension of the timeframe must be in writing and must clearly state why the request for reconsideration was not filed on time. It is within the plan's discretion to accept or deny the request for an extension." Rational for recommended change #2: 42 CFR §422.582 allows an extension of the timeframe for filing a request for reconsideration if the enrollee can show good cause for the delay. The request must be in writing and must state the reason why the request was not filed on time. The current NDMPC does not instruct enrollees to send their request for an extension in	this type of requirement. In addition, an extension could be applied, changing the date and causing confusion for the beneficiary. 3. CMS believes the recommended change is not in easily understandable language for the beneficiary and that the current language is understandable and refers beneficiaries to the plan to get further instruction on how to file an extension. 4. CMS believes the term "expedited" as referred to in Medicare regulations, is primarily used by health plans and providers and is not considered understandable language for the beneficiary. 5. CMs agrees and has included language in the notice instructions that plans may remove the fast appeals section if the notice is for a payment denial. 6. The IDN is an OMB approved form and can only be modified in the free-text fields, as appropriate. The plan cannot include additional forms with the IDN.

		writing. In addition, it is our experience that enrollees who receive this NDMPC are often experiencing a health care crisis, often miss the deadline for filing an appeal, and thus, need an extension to file an appeal. It is also our experience that when an enrollee does appeal and requests an extension, the health plan often denies the request. The importance of appealing within 60 days and the fact that an extension of time to appeal is not guaranteed should be underscored. 4. <u>Section entitled Important Information About Your Appeal Rights</u> Recommended change #1- Instead of calling it a Fast Appeal, the NDMPC should refer to an Expedited or Fast Appeal. Rationale for recommended change #1: The Medicare regulations as well as the Medicare Managed Care Manual refer to this type of appeal as an "Expedited" appeal request. Keeping the language used in Medicare regulations, Manual provisions and the NDMPC consistent would help to minimize any potential confusion. 5. Recommended change #2: The NDMPC should make it clear that a Part C Medicare organization will expedite a request for appeal that involves specific issues including: § The Part C organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Part C organization; and § Reduction, or premature discontinuation of a previously authorized ongoing course of treatment. In addition, the NDMPC should state in the description of an expedited appeal that a Part C Medicare organization will not expedite an appeal request for payment of services already furnished. Rationale for recommended change #2: 42 CFR §422.584(a) only allows expedited appeals for certain issues. The description of a standard appeals says that if an appeal is for payment of a service already received, a decision will be given within 60 days. However the description of a "Fast Appeal" makes it sound like an enrollee will	

		automatically get a fast appeal if the doctor asks for one or supports a request regardless of what type of appeal it is. 6. <u>Section entitled How to ask for an appeal {health plan name}</u> Recommended change: The NDMPC should include a model form for enrollees to use when filing an appeal. Rationale for recommended change: Those who have traditional Medicare, rather than a Part C Medicare plan, are given appeal forms at every stage of the appeals process. The redesigned Medicare Summary Notice has a form on the last page of the notice with step-by-step directions on how to fill out the form and request a redetermination decision. The redetermination decision includes a Reconsideration Request Form that an individual can use to request an appeal to the next level. The reconsideration decision includes a link to a form to be used when requesting an Administrative Law Judge hearing. Often times those who receive notices regarding their health care are in crisis and including a form to use when appealing will ensure all required information is included with an appeal. Also an appeal form is more likely to be noticed by a Part C Medicare organization as an appeal, rather than a grievance or a complaint, which are handled and processed differently.	
Instructions, Notice		Health Care Service Corporation, Sue Rohan 1. <u>Section titled "Why Did We Deny Your Request?"</u> CMS has added a paragraph in the instructions for the Notice of Denial of Medical Coverage (or Payment) in the Why did we deny your request section. It appears that this instruction would require plans to send the Notice for any service that is exclusively a Medicaid-covered service that would never be covered by Medicare. HCSC is concerned that the new instruction is placing a new requirement on plans that would greatly expand the use of the Notice, requiring it to be issued every time a Medicaid service is covered in a Medicare plan that manages the member's Medicaid benefits. This instruction would require mailing millions of Notices, especially since Medicaid-only covered services are often high frequency services such as personal care, transportation and interpreter services. The approach encompassed in this new	1. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to increase member confusion, increase administrative burden for plans and increase the number of appeals. Therefore, we have made appropriate revisions the instructions. The instructions now state: -plans must determine if services are covered under the plan's

		instruction seems contrary to what CMS, States, and plans are striving to achieve when offering plans that integrate the Medicare and Medicaid programs to better serve the member. This new requirement could result in significant confusion and stress for members. It is likely that plans would see a commensurate increase in member inquiries, complaints, and appeals due to confusion. This could create a costly administrative burden on plans and negatively impact Star Ratings. HCSC recommends that CMS eliminate the new instruction to avoid member confusion and administrative complexity. Alternatively, we recommend that CMS (1) clarify the new instruction applies only in situations where a service or item could be covered by either Medicare or Medicaid, but under different criteria and (2) exclude services that are covered only by Medicaid.	Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued.
		America's Health Insurance Plans, Mark Hamelburg 1. <u>Proposed Instruction for Plans that Manage both Medicare and Medicaid Benefits (Why did we deny your request? instructions).</u> CMS is proposing in the form instructions for the draft notice add an instruction that would require plans that manage both Medicare and Medicaid benefits to include an explanation of coverage in the free text field when a service/item is denied under Medicare but is covered under the beneficiary's Medicaid benefits. We have several concerns with this proposed additional instruction when a benefit is denied under Medicare but fully covered under Medicaid. First, we are very concerned that language stating coverage for a service/item is denied under one payer and covered by another payer would be very confusing for beneficiaries and most likely generate beneficiary inquiries and/or appeals. We believe the primary goal for the notice of denial of medical coverage should be to provide a beneficiary with information he or she needs to appeal a service or item denied in whole or in part. When the beneficiary receives the requested coverage, details indicating that the benefit is covered under Medicaid only (e.g., long term services and supports) does not appear to provide any useful information since no appeal would be required. Further, CMS' proposed requirement should also	3. CMS acknowledges the changes in the instructions regarding when CMS-10003 should be issued has the potential to increase member confusion. Therefore, we have made appropriate revisions the instructions. The instructions now state: -plans must determine if services are covered under the plan's Medicare and/or Medicaid benefit; -the criteria plans are to take into consideration when making that determination; and -clarification on the circumstances under which the notice should be issued. 4. CMS has accepted this suggestion and replaced the reference to a page number with a reference to the name of the applicable section.

		align with the agency's commitment as indicated in the CY 2016 Call Letter, to support efforts to provide more seamless integrated Medicare and Medicaid benefits and better communicate these benefits to dually eligible beneficiaries. The agency's proposal however, is inconsistent with treating the benefits as an integrated whole. Lastly, we note that a number of states have worked with plans to develop coordinated messages for beneficiaries that they believe would most effectively convey information about coverage and we believe that CMS' proposal would interfere with those established processes. We therefore recommend that CMS not move forward with its proposal. If CMS is interested in exploring ways to improve notices for dually eligible beneficiaries, we recommend that the agency engage in discussions with plans to ensure that the issues raised above as well as others underlying such an effort are fully considered. 2. <u>Reference to Medicaid State Fair Hearing Section.</u> At the top of page 2 of the draft notice under the section titled, "You have the right to appeal our decision," CMS is proposing to add language that would refer dually eligible beneficiaries to the page of the denial notice that includes information about how these beneficiaries can request a Medicaid State Fair Hearing. Instead of requiring the inclusion of a particular page number, which can vary depending on the length of the notice, we believe that plans should be permitted to reference the actual heading, "How to ask for a Medicaid State Fair Hearing," for the section in the denial notice that includes this information. We recommend that CMS revise this section to reflect such an option.	