



266 West 37<sup>th</sup> Street, 3rd Floor

New York, NY 10018

212.869.3850/Fax: 212.869.3532

December 17, 2019

VIA ELECTRONIC SUBMISSION

**RE: CMS Applicable Integrated Plan Coverage Decision Letter (CMS-10716; OMB control number: 0938-New)**

The Medicare Rights Center (Medicare Rights) is pleased to submit comments on the Notice of Denial of Medical Coverage (or Payment) (Integrated Denial Notice). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The following comments are informed by our experience working with Medicare beneficiaries and their families, as they navigate both the Medicare and Medicaid appeals processes. They are also informed by our work in New York State, where we have worked closely with the Department of Health on the implementation the Fully Integrated Dual Advantage (FIDA) program through our leadership on the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE).<sup>1</sup> CPRNYDE successfully advocated for a single integrated appeals process in FIDA, allowing beneficiaries to appeal both Medicare and Medicaid denials without having to distinguish between the two systems.<sup>2</sup> We continue to work closely with New York to finalize rules for the post-FIDA duals plans as well.

Overall, we support the improvements made to the Integrated Denial Notice to make it clearer, more understandable, and more action oriented. We appreciate the additional focus on beneficiaries' rights under the Medicaid program and support the clarified requirement that health plans provide detailed, accurate reasons for denials, citing to the relevant State/Federal law or to the Evidence of Coverage sections for justification.

Below we suggest enhanced guidance related to the "free text" content, recommend stronger requirements on translation, and provide detailed language edits to make the denial notice even clearer.

---

<sup>1</sup> For more information on CPRNYDE, visit: [www.nyduals.org](http://www.nyduals.org)

<sup>2</sup> Note: Medicare Part D appeals are unchanged and all FIDA Plans utilize the existing Part D appeals process

Washington, DC Office:

1444 I Street NW, Suite 1105

Washington, DC 20005

202.637.0961

[www.medicarerights.org](http://www.medicarerights.org) [www.medicareinteractive.org](http://www.medicareinteractive.org)

## **General comments**

We appreciate the formatting changes to make the notice more open, with added white space. We have found this to improve the readability of notices and to reduce the overwhelming nature of large blocks of text. Similarly, we support the change of title to “Coverage Decision Letter” which is more accurate and, hopefully, less intimidating.

We appreciate the common-sense explanation of terms, including who “we” are and “our plan” and “the integrated plan.” In keeping with that clarity, please confirm that “your Medicare and Medicaid [Insert state-specific term for Medicaid, if applicable] services” identifies both that it is Medicaid and uses a state-specific term. It is unclear from this wording if plans would just be able to take out the word “Medicaid” and substitute the state-specific term. Both the state-specific term and the fact that it is a Medicaid program with the attendant federal protections are important for people to understand.

The organization of the information and the headers in general seems clearer and more natural.

While we appreciate that the confusing “right to appeal” and later “two kinds of appeal” sections have been removed, we are concerned about the lack of state fair hearing information, and urge CMS to revisit its inclusion.

We suggest that CMS explore the creation of a standardized form that beneficiaries can choose to use to initiate their appeal. We hear from individuals who are intimidated by the prospect of drafting an appeal from whole cloth, even with a list of required elements. A partially pre-populated form as an option may lower this particular barrier to seeking redress.

Our comments on specific headers follows:

### **“Our plan made this decision because”**

We appreciate the improvement to the heading which is both less intimidating and more accurate. We also strongly support the inclusion of guidelines for the readability of the text in the instructions, and that plans should be “conducting routine consumer testing of health plan language with LEP individuals and modifying language as needed based on testing results.”

But we would like to see model language for 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.

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 a non-English language. On translation, we urge CMS to go further and require that plans provide denial notices in the predominately spoken languages of their service areas, as plans in New York have done for several years. CMS should also require the inclusion of a multi-language insert with information about translation services for other languages.

There is currently no identification of a denial of service under Medicare when the service is covered under Medicaid. Because this can impact payment rates and, therefore, access issues, we encourage CMS to explore ways to communicate this information in a way that is understandable to beneficiaries. We appreciate the arguments for removing the version of this notice that previously existed because it could cause confusion and undue distress—implying that there was a denial or access problem where there is none—but effectively communicating this information could serve to empower patients. Thorough testing and collaboration with communication experts may assist CMS in striking this balance.

**“You have the right to appeal our decision”**

Again, we encourage CMS to revisit the decision to omit information about state fair hearing rights.

**“You can ask us for a free copy of the information we used to make our decision”**

We suggest that information is included here about how to request this information.

**“How to keep getting your <service or item> during your appeal”**

This section is much improved. We greatly appreciate the emphasis on this important beneficiary protection. It is also clearer than before.

**“What happens next”**

We appreciate that this phrase is no longer repeated in a potentially confusing way.

**“What to do if you need help with your appeal”**

This heading is improved, it is better wording than “If you want someone else to act for you.” The language is also much clearer about who the representative can be and how to make that happen. We support these changes.

**“Get help and more information”**

We appreciate this expanded section with more detail combined with an easier to read layout with more white space.

In conclusion, thank you for the opportunity to comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at [LCopeland@medicarerights.org](mailto:LCopeland@medicarerights.org) or 202-637-0961 or Casey Schwarz, Senior Counsel for Education and Federal Policy, at [CSchwarz@medicarerights.org](mailto:CSchwarz@medicarerights.org) or 212-204-6271.

Sincerely,



Fred Riccardi  
President  
Medicare Rights Center