NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

March 23, 2013

Via Electronic Mail: MMCOcapsmodel@cms.hhs.gov

Sharon Donovan
Director, Program Alignment Group
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Donovan:

The National Senior Citizens Law Center appreciates the opportunity to comment on the draft enrollment guidance for the state dual eligible demonstration projects. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation, and the education and counseling of local advocates.

We appreciate your willingness to share this draft, and your continued interest in feedback from stakeholders. Detailed comments in the format requested by MMCO are attached. In this letter we would like to briefly highlight some of the larger concerns that arose during our review, all of which we also touch on in the detailed comments.

State deference to plans for enrollment

The guidance (p. 1), while stating that it assumes that states will administer the enrollment and disenrollment process, also says that a state may defer "some or all" of these activities to the demonstration plans. Our understanding from the current MOUs and from CMS statements had been that most or all states would use enrollment brokers for enrollment and disenrollment. Guidance allowing states to offload the entire process to plans is both new and very concerning. We think use of independent enrollment brokers is a key consumer protection. While there may be parts of the enrollment process that are appropriate for the plans to handle, these specific instances should be noted in the guidance instead of granting broad authority for shifting responsibility for all parts of the process to plans. We particularly object to allowing plans to conduct passive enrollment.

Passive Enrollment

Three elements in the guidance on passive enrollment surprised us as important, new, and inconsistent with the MOUs that have been released to date.

End Stage Renal Disease (ESRD). Section 30.2.4 gives states the option of passively enrolling individuals with ESRD into the demonstration. We strongly object to moving these extremely fragile individuals in any way that is not fully voluntary.

Part D "Choosers." Section 30.1.4 excludes all choosers (dual eligibles who at any time during their Medicare enrollment made an affirmative choice for their Part D coverage) from passive enrollment into a demonstration plan. While we think this may be a good idea, it is entirely new and would have a significant impact on the size of the pool of individuals eligible for passive enrollment. The exclusion is not reflected in any of the current MOUs.

Multiple Passive Enrollments. The guidance (see, e.g., Exhibit 13) appears to say that individuals who make a decision to disenroll from a demonstration plan will be subject to another round of passive enrollment if they do not make a declaration that they want to opt out of future passive enrollment cycles. We had understood passive enrollment to be a one-time event and object to the new approach outlined in the guidance. It is confusing and also interferes with voluntary choices made by beneficiaries.

Timeliness of Data Transmissions and Beneficiary Notices

The guidance (see, e.g., Section 30.3) allows states to take as long as seven days to transmit completed enrollment and disenrollment data to CMS. Throughout the guidance, states also are given 10 days in which to mail notices to beneficiaries about enrollment and disenrollment matters. Our experience with the Medicare Part D program tells us that both of these timeframes are too long and will lead to gaps in coverage and confusion for beneficiaries. The demonstrations, from the beginning, should operate efficiently with real-time or, at least, same day data transmission between states and CMS and timely notifications to beneficiaries.

Application Form

We urge CMS to consider reformatting the draft application (Exhibit 1) so that it is more consistent with the draft application for the Exchanges, which we believe is significantly more user-friendly. http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html. Substantively, we also ask that questions be added about which language the applicant prefers for spoken and written communications. That question also is found in the draft Exchange application. Our detailed comments include other smaller suggested revisions as well.

Notices

It is critically important for the success of the demonstrations that individuals enrolling in the demonstrations receive good, carefully crafted notices. We recognize that clear and simple notices discussing both Medicare and Medicaid are very difficult to write and we appreciate the efforts to date. However, we think significantly more work remains.

Choice counseling and ombuds. The notices do not sufficiently highlight the availability of choice counseling and ombuds services. Both need to be identified more prominently in both enrollment and disenrollment notices. Further, they should be accurately described as providing "assistance," "help," or "personalized assistance," instead of "general information."

Identifying the sender. Enrollment and disenrollment notices can and should look very different depending on whether the notice is sent directly by a state agency, by an enrollment broker, or by a plan. The model notices attempt to straddle all options, something that a significant factor in their lack of clarity. We strongly recommend identifying first who will be sending a particular notice and designing the notice around that decision.

Coordinating with other notices. Several of the disenrollment notices concern the potential impact of loss of Medicare or Medicaid eligibility but make no reference to separate notices that individuals can expect to receive from CMS or the state about those underlying eligibility issues. Thought needs to be given to the full array of notices that an individual will receive as a result of any change of status so that those notices can be consistent with each other and intelligible to the beneficiary.

Individualized notices. Notices must be tailored to the individual without the beneficiary needing to figure out which box she belongs in. Several notices do not meet this test. For example, Exhibit 20, which acknowledges a change of address, should provide information on next steps based on the individual's new address (within the plan service area, in-state but outside the plan service area, out-of-state, etc.) rather than including all scenarios and requiring the individual to sort through what applies to her.

Timing

There is still much to be done before the notices should be sent to beneficiaries.

As discussed, the guidance leaves open very significant questions and also includes policy changes that are not reflected in current MOUs. These questions must be answered and communicated to states before the notices can be completed. Further, the notices need significant work to improve readability and substance. Moreover, in each demonstration state, the notices must be tailored to the circumstances of the state, particularly with respect to Medicaid options and rights. In a number of states, that step cannot be finalized until CMS approves Medicaid waivers defining those options and rights, and that approval has not yet happened.

Draft notices should be subject to consumer testing. Once the notices are modified and ready, they should be subject to consumer testing one more time and translated into multiple languages. Translated notices should also be consumer tested. In addition, before notices are actually mailed, plan, Medicare and enrollment broker customer service representatives and SHIPs need to be trained on notice content.

We do not see how this process can be completed in time for the start of the 2013 demonstrations. Passive enrollment will begin in Massachusetts in six months, and initial notices must be sent at least 60 days before passive enrollment begins. We question how CMS and the Commonwealth will complete notice preparation, testing, and consumer assistance training in the next four months. Demonstration enrolment should not start until all elements of the guidance, including accurate, clear and complete notices, are ready.

Thank you for sharing this draft and considering our suggestions. Please also note that we have read the comments submitted by the Medicare Rights Center, the Center for Medicare Advocacy, and Families U.S.A. and agree with the recommendations of these organizations.

Sincerely,

Fay Gordon
Staff Attorney

Georgia Burke
Directing Attorney

Medicare-Medicaid Plan Enrollment Guidance – Draft Comment Form

Comments due 5:00 p.m. EDT on March 22, 2013
Please e-mail all comments to MMCOcapsmodel@cms.hhs.gov

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Section Number & Page Number	Description of Issue or Question	Suggested Revision/Comment
Cover sheet (p. 1)	Delegation of enrollment functions to MMP	The guidance says that states may defer some or all of the enrollment functions and notice delivery requirements to MMPs. A state option to turn over all enrollment activities to MMPs is a startlingly new wrinkle in enrollment planning that to our knowledge has not been subjected to any stakeholder input. We recognize that delegating some notices to plans may make sense but ask for significantly more detail about what can be delegated and the rationale so that stakeholders can think through the implications for beneficiaries. We continue to believe—and had thought it had been a settled issue—that core enrollment functions, particularly those around passive enrollment, must be handled by the state or by an enrollment broker contracted with the state.
20 (p.7-8)	Enrollment cut-off date	The guidance allows states to set an enrollment cut-off date but it may not be more than five days before the end of the month. We note first that this provision is inconsistent with the Illinois MOU (p.7), which allows the state to set a cut-off date of the 12th day of

		the month. We think that the five day maximum is much better than cutting off enrollment on the 12th of the month. However, we have serious concerns about how this provision interacts with the provision allowing states up to seven days to transmit enrollment information to CMS. As discussed below, the solution is not an earlier enrollment cut-off but rather a requirement that states transmit enrollment information to CMS in real time or at least on a daily basis to ensure timely recognition of enrollment.
30.1.4 (p. 13)	Who is subject to passive enrollment	We appreciate the inclusion of PACE members and individuals receiving hospice among those not subject to passive enrollment. The guidance also exempts from passive enrollment: "individuals who have opted out of auto-enrollment into a Part D plan (since MMPs qualify as a Part D plan." While we think that approach may be a good one, we note that it is a significant new policy with major impact on the size of the pool of individual potentially subject to passive enrollment. It is a policy that has not been discussed earlier and that is not reflected in any of the existing MOUs.
30.1.4.E (p. 15)	Opting out of Part D auto enrollment	We share CMS's concern about individuals who need to opt out of Part D coverage in order to maintain other health coverage. In addition to the requirements placed on the states in this guidance, we ask that CMS ensure that its own systems independently track the prior Part D status of an individual who opts out of a demonstration. If that individual had previously declined auto-enrollment into Part D, the individual should automatically be returned to his prior status, for example, to fee-for-service with no Part D plan.
30.1.4.F (p. 15)	Employer coverage	We appreciate the efforts to protect access to employer and union coverage.
30.1.4.H (p. 15)	Coordinating with PDP reassignment	We appreciate the thought that has gone into this process. We ask that implementation address two concerns, both of which relate to the option given to states to speed up enrollment for persons scheduled for a later date because they appear on the September CMS list of PDP reassignees. First, we ask that CMS not allow significant January bulges in passive enrollment that could affect a

		plan's ability to timely provide assessments and otherwise absorb new members. Second, we ask that CMS require that any state taking advantage of the option must have consistent messaging in its communications to potential enrollees. For example, a state should not be telling beneficiaries that they will be passively enrolled by birthday month if, in fact, that rule will be broken for those on the September PDP reassignment list.
30.2 (p. 18)	Using Medicare card to verify enrollment information	Allow use of Medicaid card as well since many dual eligibles may be carrying that instead.
30.2.A (p. 19)	Verifying permanent residence	We have concerns about the requirement to contact the individual to verify residence. If an individual is homeless, that individual is often very hard to reach. The requirement for direct contact seems inconsistent with the provision of Sec. 10.2 that a P.O. box can be used as the residence address for a homeless person. We suggest that, at a minimum, the requirement for contact be waived if the state or CMS has information indicating that the individual is homeless.
30.2.2. (p. 24)	Incomplete enrollments-requesting information	If an oral contact is made and the needed information is not provided during the course of the telephone call, the state should be required to follow up with a written request that highlights the 21 day deadline.
30.2.4. (p. 24)	Enrollment of persons with ESRD	This section permits states to passively enroll persons with ESRD into MMPs. It contradicts Section 30.1.4, which specifically excludes those individuals from passive enrollment. It also appears to be a significant change in policy for the demonstrations that has not been aired with stakeholders. We urge CMS to categorically exclude persons with ESRD from passive enrollment into MMPs. Uninterrupted care is absolutely critical to the health of people with ESRD. When California moved Seniors and Persons with Disabilities who do not qualify for Medicare into mandatory managed care, individuals with ESRD comprised a group with one of the highest incidence of transition problems. The California experience demonstrates the need to

		exercise extreme caution with this subpopulation. We do not object to permitting persons with ESRD to enroll voluntarily in MMPs if they choose and if the MMPs have first demonstrated that their networks are equipped to serve the needs of this population. Passive enrollment however is far too risky.
30.3 (p. 26-27)	Transmission of enrollments to CMS	CMS should not allow states seven days in which to transmit enrollment transactions. As CMS is aware, data transmission delays have been a major source of problems for beneficiaries in Part D. Though improvements by CMS and Medicare plans in timeliness of transmission have alleviated problems, advocates report continued gaps requiring LI-NET coverage because many states continue with infrequent transmissions. Yet some states, including Ohio, a demonstration state, have been able to transmit MMA files almost daily to CMS. CMS can and should require more of all demonstration states. We also note that the Exchanges are focusing on real time data exchange whenever possible. Real time data transmission should also be the standard for the demonstrations. If real time transmissions cannot be achieved in the demonstrations, at least daily submissions should be required. We appreciate the note that the requirements for transmittal do not affect the effective date of enrollment. As a practical matter, however, we question how a state is going to be able to ensure availability of MMP services if it cannot even transmit enrollment information to CMS in a timely manner.
30.4.1. (p. 29)	Notice of charges for which the member will be liable	We ask that CMS clearly require that this notice be particularized to the individual. For example, the actual LIS co-pay applicable to the individual should be shown. There should not be charts or lists where the individual needs to figure out which category applies to her. Similarly, statements such as "Your co-payment will be no more than x" are not sufficient.

30.4.1. (p. 29)	Notice of potential financial liability	We do not understand the need for a notice of potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B and enrolled in Medicaid. The notice could frighten individuals and deter them from seeking needed care. This notice is particularly inappropriate for someone who is passively enrolled. Absent fraud, that person should have no potential liability based on an enrollment that he did not even initiate.
40 (p. 32)	Disenrollments	We agree that MMPs should not accept disenrollments directly from individuals. This prohibition, however, appears to be subject to override by the guidance on page 1 allowing delegation of all enrollment functions to MMPs (See our first comment.) We ask that CMS provide more clarity and strictly limit the role of MMPs in enrollment and disenrollment.
40.1 (p. 32-33)	Need to opt out of passive enrollment when disenrolling from an MMP	This section provides that the state must ask whether the individual wants to opt out of passive enrollment into MMPs. (The guidance is unclear about whether this requirement only applies when an individual submits a disenrollment request through the state.) We believe that exemption from another passive enrollment should be automatic for any individual who disenrolls from an MMP. The state should not need to make further inquiries to the individual. Such inquiries could be very confusing, particularly if the individual has enrolled in another non-demonstration plan. In other words, passive enrollment should happen no more than once for any individual. If that person opts out prior to the effective date of enrollment, the guidance prohibits future passive enrollments (See Sec. 30.1.4). Similarly if she disenrolls anytime after the effective date of the enrollment, she also should be exempt from any further passive enrollment during the life of the demonstration. Further, whatever the manner in which the individual makes a disenrollment request, it is important that the entity receiving that

		request affirmatively provide specific information to the individual on how to get choice counseling assistance. Disenrolling individuals need to understand the impact of their decision on how they receive Medicaid benefits. They also need to understand their full range of Medicare choices. The issues are complex and one-on-one choice counseling at this stage is as important as when the individual first makes a decision about enrollment in an MMP. If individuals disenroll by phone or in person using any route (state, Medicare, new MA or PDP), there should be mandatory scripts urging the individual to contact a choice counselor and giving specific contact information for that choice counseling. Disenrollment notices should also stress the availability of counseling (see our comments below re Exh. 14).
40.1.3 (P. 33)	Telling providers to delay Medicare billing	We understand the value of telling providers to delay Medicare billing for a recently disenrolled individual but think asking the beneficiary to explain the request will not work. We suggest including with Exh. 13 an insert with a simple statement that the individual can show to providers (see our comments below on the notice). More basically, we question why delays in recognition of changes in coverage should be routine. Data transmission by all involved parties should be in real time or, at least, on a daily basis. Beneficiaries and their providers should not have to navigate delays that could be avoided by timely data transmission.
40.2.1 (p. 35)	Change of residence	Exhibit 20 must be much more tailored to the individual's circumstances. There could be many scenarios involving a change of address and, when the state knows the beneficiary's new address, the letter should specifically discuss the move to that address. For example, if the individual is moving from one part of the state where demonstration plans operate to another where there also are demonstration plans, that fact should be in the letter. If the demonstration is not available in the individual's new home zip code, that too needs to be explained. Individuals moving out of state will lose Medicaid status and need to be told to

		reapply. Individuals in those circumstances need a different letter and that letter must be coordinated with whatever other notices the state may be sending about loss of Medicaid coverage. This section also raises for us a question that we have not seen addressed directly anywhere in the guidance or in the MOUs. In those states where demonstrations are not statewide, what happens to an individual who moves within a state from a non-demonstration county to a demonstration county during the demonstration period? Will that individual be subject to passive enrollment? Another question is whether the procedures and timelines here are consistent with state Medicaid procedures when the move or suspected move is to an out-of-state address.
40.2 (p. 34-35)	Required involuntary disenrollments	This is the first time that we have seen the policy decision that the appeals mechanism for these disenrollments will be the state grievance procedure. There should be stakeholder input, particularly by advocates in the states, before deciding whether this is the most appropriate choice.
40.2.2 (p. 39)	Loss of Part A or Part B	Individuals being involuntarily disenrolled because of loss of Part A or Part B need more than a notice about the reasons. They also need specific information about what this means for their coverage choices. Letters must be particularized to the individual's circumstances. For individuals losing Part A and/or Part B could mean no Medicare coverage and they will be getting all their health care through Medicaid. For others who retain eligibility for one category of Medicare coverage, it might mean that they can join a PDP (and will be auto-enrolled if they do not) and get Original Medicare but cannot join a Medicare Advantage plan. In all cases, the notices need to include a strong push to getting one-on-one assistance. We are not sure whether it would be clearer to include this information in a separate notice from the notice that alerts the

		individual to the reason for disenrollment but recommend that these issues be thought through more fully.
40.2.3 (p. 39)	Loss of Medicaid eligibility.	As a preliminary matter, we note that any disenrollment because of loss of Medicaid eligibility must be preceded by a review by the state of the individual's eligibility for any other Medicaid programs including Medicare Savings Program. We also raise the question of whether this is a situation in which the least disruptive course for the beneficiary would be to automatically move him into a Medicare Advantage plan operated by the same plan sponsor, if such a plan exists, rather than defaulting him into fee for service. The guidance also assumes that some disenrolled individuals will no longer have LIS status. In fact, with extremely rare exceptions, all beneficiaries should have LIS status for at least 5 months after loss of Medicaid status.[1] Exhibit 21 should be tailored to the individual's specific circumstances with respect to LIS status rather than giving a general rule and leaving it to the individual to figure out where she fits. Further, the notice needs to spell out clearly that Medicaid coverage will be lost and what this means. Also, an individual losing Medicaid coverage will be getting separate notices from the state about loss of eligibility. The language, timing and content of a notice such as Exhibit 21 should be coordinated with those notices.
40.2.5 (p. 40)	Disenrollment notices because of plan termination.	Besides describing the effect on an individual's Medicare coverage and on Medicare choices, a notice of disenrollment because of termination or non renewal must also describe the impact on Medicaid benefits and the Medicaid options available to the

[1] If an individual loses Medicaid status in any month between January and July, LIS will continue through December of that year. If Medicaid is lost from August onward, LIS will continue through December of the following year.

		individual.
40.3 (p. 41)	Grievance procedure for optional disenrollment.	Here, as with mandatory disenrollment, the decision to use state grievance procedures is a new one and deserves more stakeholder input, particularly from state-based advocates. We have concerns especially about state review of disenrollment for disruptive behavior since the process is designed around existing Medicare guidance and may be less familiar to state hearing officers. Also it is critical that all notices discussed in Section 40.3 contain prominent invitations to contact the ombuds for assistance.
40.3.1 (p. 42)	Disenrollment for disruptive behavior.	We appreciate the requirement for detailed documentation and that ADA principles are incorporated into the process. All notices should prominently feature the availability of ombuds assistance. Further, besides the notices listed, there also needs to be a detailed final disenrollment notice that tells the individual about default enrollment, any restrictions on re-enrollment and other options. This is another case where directing the individual to choice counseling is critically important.
40.3.1 (p. 43)	Reasonable accommodation in exceptional circumstances.	We do not understand the first bullet on p. 43 concerning reasonable accommodation for an individual who is disenrolled. Does this refer to accommodation while transitioning the individual out of the MMP?
40.3.2 (p. 44)	Disenrollment for fraud	We ask that CMS ensure that adequate consumer protections are in place with respect to findings of fraud. Given the disproportionate prevalence of low literacy, limited English proficiency and cognitive impairment in the demonstration population, it is often the case that fraud, if found, is not being perpetrated by the beneficiary himself. It is important that vulnerable beneficiaries not be penalized for the acts of others. With respect to the specific issue of fraud in connection with an

		application, we note that little opportunity for fraud exists. Very little information is requested and almost all is immediately verifiable.
40.4.1 (p. 44)	State transmittal of voluntary disenrollments	As noted above, giving states seven days in which to submit disenrollment requests is too long and can harm beneficiaries. We also repeat our comment made in connection with Sec. 40.1, that we do not think that an individual who chooses to disenroll from an MMP should be required to take the additional step of affirming a desire not to again be passively enrolled into the demonstration.
50 (p. 47)	Post enrollment coordination between the state and MMPs.	We strongly agree that questions of which entity sends which notice need to be fully addressed well before any enrollment takes place. They also should be addressed before any model notices are finalized. The identity of the party sending a notice has a significant impact on the form and contact of that notice. Moreover, there needs to be significant systems testing of both state and MMP systems to determine whether each of the systems actually works as designed and whether the right notices can be produced in a timely manner. Testing should cover a wide range of scenarios, including those where individualized information needs to be part of the notice.
50.2 (p. 47-48)	Opt out procedures	We appreciate and agree with the decision to require the state to accept verbal opt-outs. For many members of the demonstration population, filling out written forms and mailing them is a daunting task.
Exhibit 1, pg. 69	Form lacks a headline the purpose of the notice.	Include a headline informing the beneficiary what the form is. For example: **Medicare-Medicaid Application Form**.
Ex. 1, pg. 69	No information about other formats or language *until the end of the form.*	This information should be at the beginning, before the beneficiary tries to fill out the form. Include a text box at the beginning with the following language: This form can be provided upon request in alternative formats. Other formats may include (but are not limited to) large print, Braille, audio recordings, Web-based communications, and other electronic formats. Call <phone

		number> to arrange for an alternative format that will work best for you. You can also get this form in another non-English language. Or you can get an interpreter. Call <plan number> to get the information in a language that works best for you.
Exhibit 1, pg. 69	No information about help for the beneficiary before they are instructed to fill out the form.	Following the alternative formats and before the "Choose a health plan" section, the form should explain that the beneficiary can receive counseling and help. For example: Remember, help is always available. For help in choosing the health care plan that is right for you, contact your State Health Insurance Assistance Program (SHIP) at <SHIP number>. If you have a problem, you can call the <Medicaid> ombudsman at <ombudsman number>. The language in the current draft saying that SHIPs and Ombuds can give "general information" sends the wrong message. These resources are available for personalized assistance. If this language is not at the top of the form, we suggest including the above information in a cover sheet to the application. The CMS Draft Exchange application (Exchange Form) has a helpful cover sheet that explains where the applicant can get help, what happens next, where to apply on-line, and a language option. The draft application is available here: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html. We also assume throughout this and other forms that the reference to SHIPs is a placeholder for whatever network of choice counseling a state sets up. While we expect that SHIPs will be a core part of all state choice counseling networks, it is likely that other entities will also be involved and/or other names will be used to identify the counseling function for the demonstration.

Exhibit 1, pg. 69	Language is not appropriate and placement is inadequate: "*If you are not a native English speaker, you can call <phone number> to get the form in a different language"*	Remove this box, as the explanation of language accessibility should be at the beginning of the document. *See* previous comment. Also, replace with a section asking the beneficiary about preferred language. For example, ask: Preferred Language Spoken (if not English) and Preferred Language Read (if no English). *See* Exchange Form, Step 1.
Exhibit 1, pg. 70	Beneficiaries should be aware of counseling and information before signing the form: *"When you sign this form, it means you understand.."*	*See* above comment about including SHIP and ombuds information at the top of the form. This is important information and must precede any instruction to sign the form.
Exhibit 1, pg. 70	Requires the beneficiary to sign an agreement on issues they should not have give consent to.	Suggest removing this section and including a form similar to STEP 4 in the Exchange Draft where the beneficiary's attestation precedes the remaining information. This order ensures the beneficiary provides true and accurate information, and does not require the beneficiary to agree to issues the beneficiary should not have to consent to in order to receive coverage. Further, omit the reference to perjury penalties, which can create unnecessary apprehension.
Exhibit 1, pg. 71	Inappropriate to require beneficiary to agree to. *"If I move, I need to tell <State/enrollment broker> so I can leave that plan and find a new plan in my area."*	Omit "so I can leave that plan and find a new plan in my area." Moving can have many consequences, ranging from the simple recording of an address change within the same area to losing Medicaid coverage altogether because of an out-of-state move. The current wording captures only one of those consequences. A simple requirement to report should be enough for the form.
Exhibit 1, pg. 71	Inappropriate to require beneficiary to agree to. *"I will read the <Member Handbook> from <plan> to know which rules I must follow."*	Remove. This seems disingenuous. Realistically, members will not read the member handbook unless there is a problem. Requesting that they sign a document saying that they will read the plan would deter an honest member from signing. If there must be an attestation, consider "I understand that the Member Handbook includes the rules I must follow."

Exhibit 1, pg. 71	Information contradicts MOUs: *"On the date <plan> coverage begins, I must get my health care from <plan> doctors, except for emergency or urgently needed."*	This does not make sense and contradicts the care continuity requirements in the MOUs. As of the three signed MOUs, beneficiaries will have between 90-180 days[2] to transition from current providers to plan providers. Rewrite to be consistent with the MOUs.
Exhibit 1, pg. 71	Repetitive or contradictory: *"If I give false information on purpose, I'll be asked to leave <plan>. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the plan."*	Pick one sentence. This does not make sense-will the beneficiary be disenrolled or asked to leave?
Exhibit 1, pg. 71	Inappropriate clause for member to agree to: *"If a sales agent, broker, or other individual employed by or contracted with <plan> is helping me…<plan may pay that person."*	Change to "I understand that . . ." In the current form, it sounds like the member must agree to the broker receiving payment.
Exhibit 2, pg. 73	No information about alternative formats or languages, or help and counseling until the end of the form.	*See* comments on Exhibit 1. Same suggestion here: including a text box with information about alternative formats and languages, as well as a sentence about SHIP help and counseling at the beginning of the document.
Exhibit 2, pg. 73	No heading to explain the purpose of the form.	Include a heading at the beginning that explains: **SHORT ENROLLMENT REQUEST FORM: SWITCHING TO ANOTHER <PLAN NAME> PLAN**
Exhibit 2, pg. 73	Language is not appropriate and placement is inadequate: "*If you are not a native English speaker, you can call <phone number> to get the form in a different language."*	*See* comments in Exhibit 1 about including a text box with information about language accessibility at the beginning. Also, remove sentence and replace with language consistent with the recommendation in Exhibit 1 and the Exchange Application: For example ask: Preferred Language Spoken (if not English) and Preferred Language Read (if no English). *See* CMS draft Exchange

[2] Care continuity requirements in the three MOUs: Massachusetts: 90 day transition period, or until the plan completes an assessment. Ohio: High risk beneficiaries will continue to receive services for 90 days, and other beneficiaries have a year to transition. Illinois: Includes a 180 day transition period for continuing a current course of treatment.

		Form.
Exhibits 3 and 4	Design of exhibits depending on whether they are sent by the state or the plan.	Although we have made numerous suggestions below for technical changes in these exhibits, a foundational concern is the question of who will be sending them. If the state is sending them and the plan will be following up with detailed information about how to access plan services, then they can be considerably shorter. If the plan is sending them, then significant details should be incorporated in the letter. The fact that the enrollment guidance leaves open the issue of plan responsibility versus state responsibility makes review of these documents very difficult. Deciding who is doing the communicating is a necessary first step before designing the communications.
Exhibit 3, pg. 77	No headline to clearly explain the purpose of the notice.	Insert a headline at the top of the notice: **IMPORTANT INFORMATION ABOUT YOUR NEW MEDICARE-MEDICAID PLAN.**
Exhibit 3, pg. 77	No information about alternative formats or languages, or help and counseling until the end of the form.	*See* comments on Exhibit 1. Suggesting the same thing here: including a text box with information about alternative formats and languages, as well as a sentence about SHIP help and counseling at the beginning of the document.
Exhibit 3 Pg. 77	Opening sentence	The letter should start by acknowledging receipt of the completed enrollment request. "Thank you for submitting a request to enroll in the <plan name> Medicare-Medicaid Plan."
Exhibit 3, pg. 77	The clause that tells the beneficiary to use the letter as proof of coverage is inadequate.	Like Exhibit 1, include a text box that says "Keep a copy of this letter. " This letter will be the beneficiary's only proof of coverage for 10 days. The beneficiary needs clear information to hold on to the letter as proof of coverage.
Exhibit 3, Pg. 77	"long term services and supports include services that help improve a long-term medical condition . . .	Delete "that help improve". Insert "for".

Exhibit 3, pg. 77	Potentially inaccurate information about plan services: • *Extra benefits and services, including a care coordinator, and…*	This may be misleading and inaccurate information, and should be tailored to exactly what the beneficiary can expect from the plan. For example, in Illinois, the MOU does not clarify that the beneficiary will receive *any* extra benefits outside of the current waiver services and Medicare benefits. The plan notice should not be informing the beneficiary about extra benefits if the plan is not providing extra benefits.
Exhibit 3, pg. 77	Information on counseling and assistance is at the end, instead of before the *What should I do now?* Section.	Information on options counseling and assistance should be explained before the beneficiary has to take action on anything. Before the *What should I do now?* section, the form should include this information: Remember, help is always available. You can call your State Health Insurance Assistance Program (SHIP) at <SHIP number> for help understanding your new plan. If you have a problem, you can call the <Medicaid> ombudsman at <ombudsman number>.
Exhibit 3 Pg. 77	What should I know about <plan>?	This section is confusing. The statement about ESRD says "you may not be able to become a member." If ESRD is a disqualifying condition, then the statement should be stronger and say "You will not be able to become a member. Call <enrollment broker at <phone number> to learn about your other choices." Also the statement "you may pay your plan copayment and coinsurance at the time for any health care you've gotten," does not fit here. It also is problematic since, to date, the MOUs have prohibited copayments except for prescription drugs. The sentence should be dropped or, if modified, put in a more appropriate place.
Exhibit 3, pg. 77-78	Confusing information about the care transition process in the *How will I get my health services in <plan>?*	Rewrite. The explanation of health services in the plan does not clearly explain the care transition rights, and is confusing. Some suggestions for alternate text: • You can continue to receive health care services with your current doctor and other providers until <number of days for care continuity>, even if they are not part of <name of plan>'s network. • Starting <end of care continuity period>, you must see a <plan> provider for all your health services. Talk to your doctor and

		other providers to find out if they are part of the plan's network. You can also call <name of plan> Member Services to find out. • If your doctor or other providers are not part of <plan>, <plan> can help you find a provider in the network that is right for you. Between now and <effective date>, a <care coordinator> from the plan will contact you to talk about your health needs and how <plan> can work with you. • Starting <end of care continuity period>, a <plan> doctor and provider must provide or arrange for all of your health services, except emergency care, urgent care, or out-of-area dialysis. Emergency care, urgent care and out-of-are dialysis are covered even if you're not seeing a <plan> doctor.
Exhibit 3, pg. 78	Inaccurate information about cost-sharing: *". . . you'll pay a reduced copayment at the pharmacy. You'll pay no more than <$_> each time you receive a <u>generic</u> drug…."*	Rewrite and tailor to the beneficiary. Some beneficiaries will have no copayment. For others, if the plan is using standard LIS co-payments, it would be misleading to say that the beneficiary will pay a "reduced" copayment, because the copayment will not be changing from what the individual is currently paying. Also please require that the drug copayment amounts be tailored to the beneficiary's specific situation (e.g., nursing home residents and HCBS with zero copayments; those with 100% FPL etc.). Beneficiaries should not be told various scenarios and have to determine which fits them.
Exhibit 3, pg. 78	No information about ombuds office in answer to help with Medicare and Medicaid.	Include a sentence following the Medicare and Medicaid contact information: "You can always call the <State Ombuds office> if you have questions or concerns about your care. Call <ombuds office number> for help.
Exhibit 4 pg. 80	Use of this letter for both voluntary and passive enrollments.	The guidance proposes to use Exhibit 4 both for voluntary (Sec. 30) and for passive (Sec. 30.1.4.D) enrollments. This letter cannot be used for both purposes. It is appropriate to confirm that a voluntary enrollment has been accepted by Medicare and

		Medicaid. It is not appropriate for passive enrollees. A different notice needs to be drafted to be sent to passive enrollees 60 days prior to the effective date of enrollment as proposed in Sec. 3.1.4**. Exhibit 4 is not an opt-out notice.** It is geared to individuals who are enrolled. It does not tell beneficiaries that they can return to their current coverage if they call within the 60 day window. An entirely new notice must be drafted for the 60 day notice contemplated in 30.1.4. Besides not having a tailored 60 day opt-out notice, this guidance also does not provide model 30 day and 90 day passive enrollment notices. Also missing are model notices around initial voluntary enrollment periods. This set of model notices is perhaps the most important among any in the demonstration.
Exhibit 4, pg. 80	No headline explaining the purpose of the notice.	Our specific comments below only relate to the use of this notice confirm voluntary enrollments. Include a headline that reads: **NOTICE ABOUT YOUR NEW HEALTH COVERAGE**
Exhibit 4, pg. 80	No information about alternative formats or languages, or help and counseling until the end of the form.	*See* comments on Exhibit 1. Same suggestion: include a text box with information about alternative formats and languages, as well as a sentence about SHIP help and counseling at the beginning of the document.
Exhibit 4 Pg. 80	Need clearer opening	We are concerned that individuals will not understand the difference between this letter and Exhibit 3. Suggest an opening sentence that links back to Exhibit 3, such as “Congratulations. Medicare and Medicaid have approved your application to get health coverage through <plan>. Your new health coverage begins .“

Exhibit 4, pg. 80	Inaccurate information about cost-sharing: *"You'll pay no more than <$_> each time you receive a <u>generic</u> drug…."*	See comments re Exhibit 3. Provide exact copayment amounts that apply to the beneficiary. If copayments are the same as the individual's current LIS amounts, do not refer to them as "reduced."
Exhibit 4 Pg. 80	What do I need to know about my new plan?	As noted re Exhibit 3, we think the current wording is confusing and should be modified. Wording in Exhibit 3 and 4 should be consistent.
Exhibit 4, pg. 81	No information about ombuds in information following *Can I leave <plan> or select a new plan?*	Rewrite. After the first sentence, insert: If you have concerns with this plan, call <State ombuds office> at <ombuds phone number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>.
Exhibit 4, pg. 80	Can I leave <plan> or select a new plan? And What if I don't want to participate in a health plan that offers the same coverage as <plan> or a new Medicare Prescription Drug Plan?	As written, these two paragraphs are hopelessly confusing. Suggest a single paragraph along the following lines. Yes. You may leave <plan> or choose a new plan at any time by calling <state enrollment broker>. If you choose a new plan, your new coverage will start the first of the month after the month you tell us you want to change. You can choose another Medicare-Medicaid plan or you can decide to receive your Medicaid and Medicare benefits separately. SHIP counselors are available to help you understand your choices and decide what is best for you. You can call <SHIP number>.
Exhibit 5, pg. 83	No headline to inform the beneficiary that the beneficiary has been automatically enrolled into a new health care plan.	Include a headline at the top of the letter: **IMPORTANT: YOU HAVE BEEN ENROLLED INTO A NEW PLAN FOR YOUR MEDICARE AND MEDICAID SERVICES.**
Exhibit 5, pg. 83	No information about alternative formats or languages.	*See* comments on Exhibit 1. Same suggestion: include a text box with information about alternative formats and languages.
Exhibit 5 Pg. 83	Long-term care bullet	Delete "that help improve". Insert "for".

Exhibit 5, pg. 83	No information about help if the beneficiary is confused about receiving the welcome letter	Somewhere on the first page, there should be a box saying: Remember, help is available. If you need help with a problem with your plan, you can call the <Medicaid> ombudsman at <ombudsman number>. Any time that you need help in deciding whether a plan is right for you, you can call your State Health Insurance Assistance Program (SHIP) at <SHIP number> .
Exhibit 5 Pg. 83	Bullets about coverage	For long term services, change "that help to improve" to "for". Modify "extra benefits" bullet if no extra benefits are required.
Exhibit 5 Pg. 83	You may begin using <plan name> network primary care providers and pharmacies . . .	Change to "You may begin using <plan name> network primary care providers and you **must use** network pharmacies . . ." As we understand it, there is no transition policy for out-of-network pharmacies.
Exhibit 5, pg. 83	Information about holding on to letter as proof of coverage should be bold.	The sentence at the end of the page is inadequate. Like the current Exhibit 1, include a text box that says "Keep a copy of this letter." This letter will be the beneficiary's only proof of coverage until the membership card arrives. The beneficiary needs clear information to hold on to the letter as proof of coverage.
Exhibit 5, pg. 84	Inaccurate information about cost-sharing.	*See* comment in Exhibit 4, pg. 80. Rewrite and tailor cost-sharing information to the beneficiary.
Exhibit 5 Pg. 84	What if I don't want to participate in <plan name>?	Because there will still be time to opt out when the individual receives this letter, this section should come before "What if I want to join another Medicare-Medicaid plan." Add a sentence with the opt-out deadline, e.g., To be sure that there is no interruption in your coverage, call before <enrollment effective date>. Also, as noted in our comments on the guidance, individuals should not have to affirmatively state that they do not want further passive enrollment. Any voluntary choice should end all future passive enrollments into the demonstration.
Exhibit 5, pg. 85	No information about ombuds in information following *Can I leave <plan> or select a new plan?*	*See* comment in Exhibit 4, pg. 80. Include information about ombuds and SHIP counseling here.

Exhibit 6-12	Needs a headline and an opening sentence to provide context, needs an explanation of alternate formats and languages, and reminder about help and assistance from SHIPs and ombuds offices before the detailed information in the document.	Add headline: Request for information. Add an opening sentence: Thank you for submitting an application to join <plan>. Some information was missing. *See* second and third comment on Exhibit 1. Include changes in Exhibit 6-12.
Exhibits 9 and 10 pg. 92-94	"We will send you a bill for any health services the <plan> paid for you."	We do not understand this process. If an individual's enrollment was denied, that person still has some coverage through fee for service Medicare and/or Medicaid or a previous plan. The dual eligible individual should not be sent a bill and be told to figure out how to handle it. There needs to be a better process and that process should be explained in the letter.
Exhibit 11 pg 95	It may take up to 45 days for your records to be updated.	We do not understand why it should take so long to process a cancellation. Data transmission should be in real time or, at least, daily.
Exhibit 11 pg 95	What if I don't want to participate . . .	As stated earlier, an individual should not have to affirmatively refuse further passive enrollment into a demonstration. The situation differs from passive enrollment in a Part D plan. Without Part D enrollment, an individual has no drug coverage. Without demonstration enrollment, an individual still has Medicare and Medicaid coverage.
Exhibit 12, pg. 97	Needs a clear headline explaining the beneficiary requested to switch to Original Medicare.	Suggest adding a headline: **DISENROLLMENT FORM: USE THIS FORM TO ENROLL IN ORIGINAL MEDICARE**
Exhibit 12, pg. 97	Required language following "*When you leave <plan>, you will no longer have…"* is not informative and is distracting.	Remove. A beneficiary requesting this disenrollment form made a decision to disenroll in the plan and return to Original Medicare. She does not need information from the plan about the benefits of the plan that she will no longer receive. If she decided to disenroll from the plan, she made the decision because the plan is not adequate. Also, if there is information about SHIP counseling, she will be aware of resources that she can use to find out what the plan offers compared to Original Medicare.

Exhibit 12, pg. 97	"Use the Disenrollment Form…"	This section is very confusing to us. We do not understand the scope of duties of the enrollment broker. If the enrollment broker cannot handle enrollments into non-demonstration plans, then there should be a mechanism for a "warm" handoff to SHIP counseling and/or 1-800-Medicare. Individuals should not be sent a confusing form that is only applicable in the rare case where they want to decline both demonstration passive enrollment and Part D coverage.
Exhibit 13, pg. 99	Text box on information in other languages needs more information.	Add information about alternative formats to this text box. *See* Comment on Exhibit 1 for suggested information.
Exhibit 13, pg. 99	Include a text box with a reminder about Medicare billing.	*See* comments Section 40.1.3 of Enrollment Guidance. Include language from Exhibit 14 in a text box at the top of Exhibit 13: It will take a few weeks for us to make this change and update our records. If your doctors need to send claims, tell them you just left a <plan> and there may be a delay in updating your records. Again we question why it should take weeks to process a disenrollment and urge timely data transfer in order to avoid delays.
Exhibit 13, pg. 99	The bullet with this sentence: "*…<state> may enroll you in another Medicare-Medicaid plan, unless you tell <state/enrollment broker> you don't want them to."*	Remove this clause. This form follows a letter to a beneficiary who requested to disenroll from a plan and enroll in Original Medicare. This beneficiary should not be subject to passive enrollment into another plan. The beneficiary should only be enrolled in Original Medicare.
Exhibit 13, pg. 99	The last bullet: "*You don't need to use this form…."*	Remove. If a beneficiary wants to enroll in another Medicare plan or Medicare-Medicaid plan, they should not receive this form. This form is for a beneficiary who wants to enroll in Original Medicare. This is unnecessary and confusing additional information.
Exhibit 13, pg. 100	Section 3.	Remove this section. The beneficiary requested this form because she wants to enroll in Original Medicare. Because she should not be passively enrolled into another demonstration plan, this information is unnecessary and confusing. The question on Part D also creates a danger that individuals will decline Part D enrollment because they do not understand the consequences. Those few

		individuals who want to decline Part D coverage should do so separately from this form.
Exhibit 14, pg. 102	Needs an explanation of alternate formats and languages, and reminder about help and assistance from SHIPs and ombuds offices before the detailed information in the document.	*See* second and third comment on Exhibit 1.
Exhibit 14, pg. 102	Headline should explain beneficiary needs to take action on their PDP.	Change headline to read: **IMPORTANT: YOU NEED TO CHOOSE A MEDICARE PRESCRIPTION DRUG PLAN**
Exhibit 14-17	Language access and alternative format information.	Include information about language access and information in alternative formats to the top of the notice. *See* recommended language in Exhibit 1 comments.
Exhibit 18	Information does not match the notice heading.	Notice heading reads: *Model Acknowledgement of Request to Cancel Disenrollment.* The notice does not seem to match the text. There is no acknowledgement of the request to cancel disenrollment. Include: "We've received your request to cancel disenrollment."
Exhibit 19, pg. 110	Rework the first paragraph.	The first paragraph does not clearly explain why the beneficiary was disenrolled and how she can get help. Information on why she was disenrolled is at the end of a paragraph, it should be at the beginning. Suggest revising to read: Because you didn't reply to a letter asking if you moved, you have been disenrolled from <plan>. <Plan> will no longer cover any health care services or prescription drugs you get. Remember, you always can get help. Call <State ombuds office> at <State ombuds office phone number> for assistance understanding why you were disenrolled. You can also call your <SHIP> at <SHIP phone number>.
Exhibit 19, pg. 110	No information about ombuds assistance in paragraph on grievance.	The reference to the Explanation of Coverage for help with a grievance is inadequate. Add a sentence saying that the ombuds can provide assistance.

Exhibit 20, pg. 112	Section needs to be reworked.	As with Exhibit 19, information about ombuds assistance must be included early on and repeated in the explanation of help with a grievance. Further, the notice should be tailored to the beneficiary. Because it is based on confirmation of out of area status, the state believes it knows where the individual is living. For example, if someone moved from one county to another within a state, the message might be along the following lines: It appears that you have moved to Shasta County. There are no Medicare-Medicaid plans in Shasta county but you can join a Medicare Advantage plan there or get your Medicare benefits through fee-for –service with a Part D prescription drug plan. You must get your Medicaid benefits through a Medicaid managed care plan in the county. If you do not pick one, you will be assigned to a Medicaid plan and also to a Medicare Part D plan. Contact the SHIP In Shasta County at <phone> for assistance in deciding what Medicare and Medicaid plans work best for you."The details of the notice would change based on the individual's new address and the way programs operate within and outside the state.
Exhibit 21, pg. 114	Needs an explanation of alternate formats and languages, and reminder about help and assistance from SHIPs and ombuds offices before the detailed information in the document.	*See* Comments in Exhibit 1 for examples of language.
Exhibit 21, pg. 114	Remove "*After three months have passed…"*	As a preliminary matter, no individual should receive this notice without the state having first reviewed whether the individual qualifies for any Medicaid program, including Medicare Savings Programs. Further, the three month limit is incorrect . Almost everyone who loses Medicaid status mid year has LIS through the end of the year or through the end of the following year. The notice should specifically tell the beneficiary: You still get Extra Help until at least <insert date>. As long as you receive Extra Help, you can change Medicare plans at any time.

Exhibit 22, pg. 116	Include information about ombuds office at the beginning of the document.	After the *Please verify your information* section, include: If you have a problem, you can contact <State ombuds office> at <State ombuds office phone number>.
Exhibit 23, pg. 117	Include information about alternate formats and language access at the beginning. Also include information about ombuds office and SHIP counseling.	*See* comments under Exhibit 1 for examples of language. Information on ombuds services is very important in this form, as beneficiary will be very alarmed to see their Medicare coverage may end.
Exhibit 24-26, pg. 119-124	Include information about alternative formats and language access, SHIPs and ombuds assistance at the beginning of the notice.	*See* Comments in Exhibit 1 for examples of language.
Exhibit 27, pg. 125	Remove	This notice should not be necessary for demonstration enrollments. The beneficiary should not have to request to opt-out of passive enrollment. If a beneficiary requests to disenroll from a plan into Original Medicare, she should not be eligible for passive enrollment to another plan. We also question why the enrollment broker should be handling Part D opt-outs when the broker apparently is not even handling enrollment into non-demonstration plans.
Exhibit 29, pg. 129-133	Include information on alternative formats and language access at the beginning of this document.	*See* comment under Exhibit 1.