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

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Via Electronic Mail

Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

The National Senior Citizens Law Center appreciates the opportunity to comment on the draft Member Handbook 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. We also appreciate the difficulty in creating a handbook that can be easily understood and also is sufficiently comprehensive, particularly when both Medicare and Medicaid services are included. We recognize that in many places language used in the current Model MA-PD EOC has been simplified and we thank you for that effort.

The handbook continues to be quite dense, however. It also is difficult to review when many aspects of program design, and specifically appeal procedures and rights, are still to be determined in most demonstration states.

It is important that final design of the EOC for any demonstration be a collaborative effort involving the state and state advocates and stakeholders. We hope that the model that CMS is working on will not be inflexibly imposed on states. Many states have EOC's for their existing Medicaid managed care plans, some of which may offer better or at least different approaches to handbook design and organization. Modifications to the CMS template also may be preferred to accommodate the unique design of particular demonstration projects.

We have some general comments, below. We also highlighted some more specific proposed changes and questions in "track changes" for each chapter. Note that some of the proposed wording changes in track changes assume that you will not be able to make the more global changes that we and others are suggesting.

Chapter 9

Our primary concern with the current draft is Chapter 9, and the explanation of coverage decisions, appeals and complaints.

Open with one office beneficiary can contact to help navigate a problem

The chapter opens with a list of potential problems a member may face and contact information for each of those particular problems. This format is not beneficiary friendly, and is not a process that an actual beneficiary would use when faced with a problem.

A member who turns to Chapter 9 has a problem or a complaint. From the beginning, the member needs to see information about one office they can contact to help them with their problem, whatever the problem is. We are concerned that the sample issues provided in the handbook may deter a member from seeking assistance if the member's complaint does not fit within the menu of problems provided. We recommend removing the list and providing a simple explanation about what a member can expect from a plan and the contact information for the State Duals Ombuds office to help the member navigate the problem. For example, remove the seven common problems and replace with:

> **If you are facing a problem with your health or long-term services and supports:**
>
> You should receive the health care, medications, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. If you are having a problem with your care, you can call <State Duals Ombuds Office> at <phone number> for help.
>
> This chapter will explain the different options you have for different problems and complaints, but you can always call the <State Duals Ombuds Office> to help guide you through your problem.

<u>Only detail issues the member is responsible for managing</u>

The audience for the member handbook is the member. The chapter on problems and complaints should not be muddied with information on what the provider or doctor can do when there is a problem or complaint. Much attention in the handbook is paid to coverage decision. Rather than confusing the member on how the doctor can access a coverage decision, "What is a coverage decision" in Section B, pg. 10, can be replaced with:

"Your doctor may have a question about whether or not a service is covered by our plan. Our decision is called a coverage decision. Call Member Services if you think you need a coverage decision. If you have a question or a problem about this, you can call the <State Duals Ombuds Office> for more information."

<u>Laying out an integrated process</u>

The chapter discussion of coverage determinations and Level 1 appeals does not reflect the MOUs which provide for an integrated first level of appeal. All timeframes should be the better of the Medicare and Medicaid timeframes. Also the discussion should explain integrated review by the plan, explaining that the plan will review all coverage decision requests using both Medicare and Medicaid standards.

<u>Information on appeals should highlight appeals assistance and time sensitivity from the beginning</u>

The information on the appeals process fails to highlight the critical information the member needs to initiate an appeal. If members have a problem, they need to know two things right away: how long they have to report the problem and who can help them. On pg. 15, the handbook informs the member of the deadline for filing an appeal. This information should immediately follow the explanation of "What is an appeal?" on pg. 11. The list of offices the member can contact for help when making an appeal on pg. 11 is not helpful, and will lead to greater confusion and frustration for the members as they determine which office can help them initiate an appeal. Instead, the members should be directed one office that will help them directly, or connect them to the appropriate office that will assist them in navigating their appeal. For example, the list on pg. 11 following "What is an appeal?" should be removed, and replaced with this information box:

> **You have** <insert number> **days to make an appeal** from the date on the letter we sent you about our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
>
> **You can get help when you ask for an appeal.** The <State Duals Ombuds Office> will help you with your appeal, or give you information on an office or agency that can help you. The phone number is <insert phone number>.

<u>Detailed appeal information should be limited to Level 1 and 2</u>

We appreciate the attempt to provide members with all options and information, but we are concerned that the discussion of Level 3 appeals and beyond may confuse members navigating the appeals process. Members who are turned down from both the Level 1 and 2 appeals will receive a letter explaining options for continuing the review process. At that point, the letter should include the information on pursuing a Level 3 appeal and beyond. The discussion on pages 45-49 can be replaced with the following paragraph:

> **After your Level 1 and Level 2 Appeal Decision:**
> If you made a Level 1 Appeal and a Level 2 Appeal for *Medicare* services, and both your appeals have been turned down, you have the right to additional levels of appeal. You can ask an Administrative Law Judge to hear your appeal and after that can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal. You will receive a letter from the Independent Review Organization telling you what to do if you wish to continue the review process. After you receive the letter, if you need further assistance, you can contact the <State Duals Ombuds Office>. Their phone number is <insert phone number>.
>
> You also have more appeal rights if your appeal is about services that might be covered by Medicaid (go to a similar level of detail).

<u>The handbook should include information about physical accessibility and language access</u>
We were surprised to see the section on complaints was completely devoid of any mention of issues with accessibility. Section F says that the complaint process is used *only* (emphasis included) for certain types of complaints, and lists the possible problems handled by the

complaint process. Often, a member's problem with a plan results from provider's decision not to physically accommodate a member, or a refusal to provide interpreter services. These are two areas where a member has a right to file a complaint, and yet, they are not listed in the complaint section. The following language should be added to pg. 50:

> ***Complaints about physical accessibility***
> - You cannot physically access the health care services and facilities in a doctor or providers office.
>
> ***Complaints about language access***
> - Your doctor or provider does not provide you with interpreter services during your appointment.
>
> If you have a complaint about disability access or about language assistance, you also can file a complaint with the Office of Civil Rights at the Department of Health and Human Services, <insert phone number>. You may also have rights under the Americans with Disability Act and under <insert relevant state law>. You can contact <State Duals Ombuds Office> for assistance.

Chapter 10

We continue to have questions about how disenrollment from the demonstration and enrollment in another Medicare plan will operate. Specifically we do not understand whether the enrollment broker will be assisting with enrollment in non-demonstration plans or if the individual will then need to make a separate contact for the non-demonstration enrollment. If two steps are needed, that should be made clear in this section.

Chapter 11

Subrogation is a particularly difficult concept for a lay reader. We suggest examples such as: "Sometimes someone else has an obligation to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work."

Chapter 12

Some definitions do not appear to be necessary. There also is a need to include other definitions related to Medicaid services and processes. Two that come to mind are "aid paid pending" and "fair hearing." We have included some more specific comments in track changes.

Thank you for sharing this draft and considering our suggestions.

Sincerely,

Fay Gordon
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Georgia Burke
Directing Attorney