

**2010 ANOC/EOC**

**Industry Comment/Response Form**

<b>Plan/Non-health Plan Entity:</b> National Senior Citizens Law Center, California Health Advocates, Center for Medicare Advocacy, and Health Assistance Partnership				
<b>Contact Person Name:</b> Georgia Burke (NSCLC), David Lipschutz (CHA), Vicki Gottlich and Patricia Nemore (CMA), and Kelly Brantley (HAP)				
<b>Email:</b> gburke@nslc.org, dlipschutz@cahealthadvocates.org, VGottlich@medicareadvocacy.org, pnemore@medicareadvocacy.org, and kbrantley@hapnetwork.org				
				<b>Phone:</b>

<b>COVER LETTER</b>				
			<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			First Bullet: Please take a moment	We encourage CMS to consider this cover letter as a step-by-step guide for beneficiaries to follow to prepare for the AEP. In light of this, we suggest that these bullets be reformatted to reflect the step-by-step nature. As in, "First, you should take some time as soon as possible to read this summary. Many plans, including [insert plan name] have changes for next year. These changes may affect the services and prescription drugs the plan covers as well as what these services and drugs will cost in 2010. If you need help deciding what to do for next year, you can call your local SHIP or 1-800-MEDICARE."
			Second Bullet: If you decide to stay	As above, we encourage CMS to reformat these bullets as a step-by-step process. As in, "After you have reviewed the changes to your plan, you may decide to stay in this plan for 2010. If so, you do not have to ..." Also, we believe this bullet should encourage beneficiaries to refer to #2 to learn more about the services and costs of their plan.

**COVER LETTER**

			<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Third Bullet: If you decide to leave your plan	Modify the sentence to read, "After you have reviewed the changes to your plan, you may decide to leave this plan for 2010. If so, you can switch to a different Medicare Advantage Plan or to Original Medicare <i>and a Prescription Drug Plan</i> ...." Also, we believe this bullet should encourage beneficiaries to refer to medicare.gov or another source to learn more about the services and costs of other available plans.
			Third Bullet: If you decide to leave your plan	Edit the final sentence to: The Notice of Changes, section x ("Do you want to stay in the plan or make a change?") tells you more.
			Programs to help people with limited	Throughout the cover letter, ANOCs, and EOCs for all types of plans, the text refers beneficiaries to "programs to help people with limited resources." We believe the stand-alone term, "resources" is confusing to beneficiaries. We encourage CMS to refer in ALL these instances to "programs to help people with limited <i>income and</i> resources."
			#2: Reviewing the EOC	After the first sentence, we encourage CMS to remind beneficiaries that the Evidence of Coverage is appropriate for those who choose to stay in their same plan for 2010. Also, we suggest that CMS draw an analogy between the Evidence of Coverage and the Medicare and You handbook-- that is, it is not a tool to read from cover to cover but a tool to answer your questions throughout the year. Add the following sentence: "Look especially at the services and prescription drugs you might use to make sure you understand all of the requirements to get them."
			Reference to AEP	Under What should you do?, there should be some reference to the opportunity to change plans from November 15 through December 31. This reference can be followed by a reference to Section [X] for other time periods when a change can be made.
			MA reference	The sentence starting "To decide " is not appropriate for PDP plans. Change "other Medicare Advantage plans in your area and with Original Medicare Plan" to "other plans that are available to you."
			We're here to help!	1) Require that SHIP number be included. 2) Provide a statement about where to receive help in every language in which SSA makes information available.

## COVER LETTER

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**ANOC**

<i>Template</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
ALL			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.

<i>Template</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
ALL			Language Access	<p>On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available. Having the tagline only in English, as is done in the draft ANOC, is inadequate. In addition, each mailing should also include an insert that, in all languages that Social Security uses for its communications, stating that the mailing includes important information and that written documents or oral translations are available, along with the appropriate phone number. We noted a document on one plan's website that, with small modifications, could be adapted for this purpose. See <a href="http://www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf">www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf</a></p>
ALL			Separate ANOC for LIS beneficiaries	<p>There are some references in the draft to an LIS ANOC but it is not clear to us whether an ANOC tailored to LIS beneficiaries is required. We believe a tailored ANOC is essential. It should be sent to any beneficiary who the plan knows will qualify for the LIS for 2010. It should NOT be sent to any beneficiary who qualified for the LIS in 2009 but appears to have lost LIS subsidy status for 2010. The LIS ANOC should NOT include the reference to "Extra Help" and should NOT include the discussion of the late enrollment penalty (both on p. 2 of the ANOC). The discussion of drug tiering on p. 4 should state clearly that because you receive Extra Help, you will pay xxx for drugs in Tier 1 and yyy for drugs in all other tiers. The table on p. 5 should also reflect LIS co-pays. The discussion of changing plans, p. 6-7, should also be tailored to the situation of the LIS beneficiary, telling those who will be moved automatically out of the plan that they will be moved and must tell the plan if they want to stay (with a reference to the separate communication that they will receive from CMS). The "When can you change" section should tell LIS beneficiaries that they can change at any time.</p>

## ANOC

<i>Template</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
ALL		Notice of Changes for 2010 page and page 1	"As we have explained"	At the end of the first full paragraph in ALL the ANOCs, the text refers for those who are being passively enrolled, "As we have explained..." Please clarify in this section where passive enrollment is explained and what that means for these beneficiaries.
ALL		6 (MA), 8 (MA-PD), 10 (PFFS), and 7 (PDP)	Are you a member of an employer or retiree group?	We are concerned that the phrase, "another way of getting medical care," will be confusing to beneficiaries. We suggest that CMS change this phrase to "another type of insurance plan."
ALL		6 (MA), 9 (MA-PD), 10 (PFFS), and 7 (PDP)	SHIPs	Please add a sentence to clarify that SHIP services are free of charge for beneficiaries.
PDP	1	1	Your plan name is changing for the upcoming year: First full paragraph	Delete "or choose to enroll in Original Medicare" for PDP enrollees.
PDP	1	1	Your plan name is changing for the upcoming year: Second paragraph re reassignment within sponsor	If the individual is slated to be reassigned to another sponsor, there should be a reference to that as well.
PDP	1	1	Your plan name is changing for the upcoming year: Third paragraph re changes between plans	We are not at all sure what this paragraph is saying and believe that beneficiaries would have the same difficulty. Please clarify.
PDP	1	2	Programs to help people with limited resources	This section should use the word "income" in addition to "resources." Beneficiaries might not understand the word "resources" when it stands alone. Add a reference to Medicare Savings Programs with a referral to the State Medicaid agency or to the SHIP. Even though MSPs do not directly pay for drug costs, they do allow a beneficiary to be deemed eligible for LIS.
PDP	2	2	LIS	See comments above re LIS references.

## ANOC

<i>Template</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
PDP and MA-PD	3 (X for MA-PD)	4	Formulary	The plan formularies should have on every page a statement that people receiving Extra Help pay xxx for Cost Level 1 drugs and yyy for all other drugs. In addition, it would be helpful if the formularies were required to have a "What's New" section that lists all additions and deletions. The discussion on p. 3 should make reference to that section.
PDP	3	4	Changes to what you pay	Even if there are no changes, this section should list payment amounts for 2010 so that individuals have the information in front of them and can easily compare their current plan with competitor products.
PDP and MA-PD and PFFS		5 (PFFS and MA-PD), 3 (PDP)	Changes to your benefits, prior to "Please check to see if any of these changes to drug coverage affect the drugs you use."	Add to both bullets above this point: (See <b>What if changes for 2010 affect drugs you are taking now?</b> , below on page x.)
PDP	3	5	Drug cost box	The distinction between co-payments and coinsurance is likely to confuse many beneficiaries. We suggest dropping the terms and simply saying "you pay xxx"
PDP	3	5	Transition supplies	Instructions in the draft tell plans that they may omit the bullet at the bottom of page 5 if they allow current members to request formulary exceptions in advance for the following year. We urge instead that CMS require this sentence whether or not a plan allows advance exception requests. The CMS formulary guidance at 30.4.5 states clearly that plans must provide transition supplies to any member who has not successfully transitioned before January 1, even if advance exceptions are allowed. The ANOC should make this clear by retaining this sentence for all members.
PDP	4	6	"Do you want to make a change?"	In the first paragraph under this heading, the reference to "Original Medicare without a separate Medicare prescription drug plan" is confusing. We recommend, "you can switch to a different Medicare prescription drug plan, join a Medicare Advantage plan, or drop Medicare prescription drug coverage." It also would be helpful to add a sentence warning that dropping coverage if you do not have creditable coverage could result in a late enrollment penalty if you decide to sign up for Part D coverage some time in the future.

<i>Template</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
PDP	4	6	When can you change	This section uses the term "annual coordinated election period" while the EOC uses the term "annual election period." Terminology should be consistent. Also the description of changes for PDP enrollees should be as above.
PDP			Missing discussion of extension of exceptions	Neither the ANOC nor the EOC discusses whether the plan will extend exceptions for the next plan year and whether a current enrollee who has an exception needs to get it renewed. This is important information that should appear somewhere in the ANOC and in the EOC as well.
MA			Programs to help people with limited resources	As with the PDP and the MA-PD ANOCs, the ANOC should include information about Medicare Savings Programs and where to apply. Also, this section should use the word "income" in addition to "resources." Beneficiaries might not understand the word "resources" when it stands alone. Add a reference to Medicare Savings Programs with a referral to the State Medicaid agency or to the SHIP. Even though MSPs do not directly pay for drug costs, they do allow a beneficiary to be deemed eligible for LIS.
MA and MA-PD	3	2	Second sentence- grammar	Our benefits and what you pay.... Will be exactly the same as <i>they are</i> in 2009
MA	3	2	Changes to what you pay	change "payer" to "pay"
MA-PD	3	3	Changes to what you pay	There is no recognition in this section of QMBs or dual eligibles for whom the state Medicaid program would be paying cost-sharing or at least, for whom there would be no cost-sharing obligation. Such people are already confused about their benefits; they will not understand that this section does not apply to them. Since not all LIS are QMBs but all QMBs are LIS, QMBs should get the separate LIS ANOC automatically and it should include language, in this section, that says something like "If your state pays your cost-sharing, these amounts do not apply to you."
MA and MA-PD	3	3	Chart - OOP maximum	Add the services that are excluded from the OOP maximum.

## ANOC

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MA	X	4	Discussion of drug coverage	These sections are confusing and need to explain more clearly the effect of enrolling in an MA-only plan on access to drug coverage. The sections should state clearly that people who enroll in an MA-only plan will have no prescription drug coverage unless they get that coverage from an employer-sponsored plan. They should also state that someone cannot retain enrollment in this plan and enroll in a PDP; enrolling in a PDP to get drug coverage will result in disenrollment from this MA plan.
MA, MA-PD, and PFFS	What about changes to the plan's network of providers?	3 (MA), 7 (MA-PD), and 7 (PFFS)	First bullet	Add the following sentence: "Generally, you have to remain in the plan even if your physician(s) leaves the plan's network during the year."
MA-PD	1	1	Programs to help people with limited resources	This section should be expanded to discuss payment for other MA-PD cost sharing, so should include reference to Qualified Medicare Beneficiary program with a number for the state Medicaid program for the individual to call.
MA-PD	1	1	Programs to help people with limited resources	The portion describing extra help should direct individuals to Social Security rather than to Medicare, as Social Security can take their application directly when they call; if they call Medicare, they will just be referred to Social Security. The direct referral will save at least one step.

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MA-PD	3	3	Changes to what you pay	There is no recognition in this section of QMBs or dual eligibles for whom the state Medicaid program would be paying cost-sharing or at least, for whom there would be no cost-sharing obligation. Such people are already confused about their benefits; they will not understand that this section does not apply to them. Since not all LIS are QMBs but all QMBs are LIS, QMBs should get the separate LIS ANOC automatically and it should include language, in this section, that says something like "If your state pays your cost-sharing, these amounts do not apply to you."
MA-PD	5	3	Changes to what you pay	The reference to changes of drugs from one cost group to another should name those drugs that have been changed, rather than directing people to the formulary.
MA-PD	5	6	What if changes for 2010 affect the drugs you are taking now?	Plans should be required to provide a temporary supply even if they offer members the opportunity to seek exceptions in advance of the plan year. Some people will not realize they have to do something until they go to purchase their drug in January.

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<b>Phone:</b>				
<b>EOC (MA-only Template)</b>				
<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
<b>We reiterate our comment that the ANOC and EOC should be provided separately. The documents are too important, and too detailed, to be provided together.</b>				
The entire EOC needs to be reviewed for consistency concerning drug coverage. Drug coverage is not relevant to the MA-only document, yet in some places it is mentioned. If the EOC is going to include information about drug coverage- other than the ability to obtain drug coverage through a different plan - then all information should be provided, including information about appeal rights.				
			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Language Access	On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available. Having the tagline only in English, as is done in the draft ANOC, is inadequate. In addition, each mailing should also include an insert that, in all languages that Social Security uses for its communications, stating that the mailing includes important information and that written documents or oral translations are available, along with the appropriate phone number. We noted a document on one plan's website that, with small modifications, could be adapted for this purpose. See <a href="http://www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf">www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf</a>
passim			Options for Special Needs Plans	We question why the EOC for MA-only plans includes language about SNPs since all SNPs must be MA-PDs
1	4.1	7-8	Many members are required to pay other Medicare premiums	Add bullet point that refers to Section 6 for information on how to get assistance paying Part B premiums for people with limited incomes and resources.
2	1	12	Member Services	Include statements in languages used by SSA to explain how to contact member services and to get assistance in the primary language spoken
2	1	13	Coverage Decisions and Appeals	This section says plans "may" include reference to 24-hour lines. All plans should be required to include their 24-hour line for coverage decisions and appeals
2	6	19-20	Discussion of Medicaid	Few dual eligibles should be enrolled in MA-only plans. We repeat our question about the optional language for SNPs. Nevertheless, they should be required to describe the Medicaid managed care program under which they contract with a state Medicaid agency. Otherwise SNP enrollees will not have complete information about the totality of benefits to which they are entitled.

**MA - ONLY**

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
2	8	21	SNPs and employer group insurance	We question the statement that people with employer group coverage are not eligible to enroll in dual SNPs in some states. As far as we know, no state Medicaid program precludes otherwise eligible individuals from receiving Medicaid because they have employer coverage. The only criterion for enrolling in a D-SNP is that the beneficiary be eligible for Medicaid.
3	1.1	24	Network providers	Add: You must use a network provider for us to pay for the services we cover; or, if you do not use a network provider you may be required to pay more for the service.
3	2.1, 2.3	26-27	Changing PCP/If a network provider leaves	SNPs should be required to include information about transition benefits.
3, 4		34 - 56	Pagination	Goes from page 34 to page 56
4		57-77	Header	The Header says Chapter 5 even though these pages contain the information in Chapter 4.
4	1	58	Header	The Header says SNPs may discuss Medicaid benefits. We repeat that SNPs cannot be MA-Only plans. However, SNPs should be required to discuss Medicaid benefits and cost-sharing in order for enrollees to understand the complete coverage to which they are entitled. In particular, they should address Medicaid cost-sharing protections and obligations.
4	1.2	59	Maximum out of pocket	Plans must be required to describe the services to which the OOP max applies, including dollar amount, in order for their enrollees to have accurate information about the benefit package.
5			Cost-sharing for dual eligibles	Again, dual eligibles should not be in MA-only plans. However, this chapter should include an explanation for duals about Medicaid coverage for their cost-sharing. It should include information on how to get reimbursed for cost-sharing that should have been paid by Medicaid, and where to send providers for information about Medicaid's reimbursement for cost-sharing.

**MA - ONLY**

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5	1.1	80	Where to send bill to get reimbursed	The first bullet under paragraph 1 should include the address where someone should send a request for reimbursement, or a reference to the page where that information can be found.
5	2.1	81	Form for requesting payment	Include a copy of the form as an attachment to the EOC.
6		60	Pagination	This chapter starts back on page 60; there are duplicate pages numbered 60-81.
6	1.5	63	Information about our plan	Add that enrollees may request information about the number of appeals.
6	1.6	65	To receive an explanation if you are denied care	This paragraph does not take into account the situations in which the plan must send a notice, even if the beneficiary does not ask for one first. The second sentence should be modified to read: In some situations you will need to ask us for a coverage determination to receive this explanation.
7	2	74	Help and information from Medicare	Add after the first sentence: You should also contact Medicare if you believe that (plan) is not following the rules for dealing with your coverage decision, appeal, or complaint.
7	4.2	76	Getting your doctor involved	The first sentence in the 3d bullet should read: <b>You need to get your doctor involved, especially if you want a fast or expedited decision.</b>
7	4.3	77	Which section of the chapter to look at	As stated above, the EOC should include information about the Part D process if information about drug coverage is to be included.
7	5.3	83	If your health requires it, ask for a "fast appeal"	Add a 3d bullet, "If your doctor tells us that your health requires a "fast appeal," we will automatically agree to give you a fast appeal." Most beneficiaries do not understand the important role of the doctor in filing an appeal.
7	5.3	85	The Independent Review Organization	Add a bullet between the 2d and 3d bullets: You have a right to give the Independent Review Organization additional information to support your appeal.
7	7.1	96	Description of the services to which section applies	In the 2d bullet change the reference to Chapter 10

**MA - ONLY**

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
7	7.4	100	Step 1 - QIO review	Add, you have the right to give the QIO additional information.
7	8	104-106	Levels 3, 4, and 5 appeals	More information is needed about these levels of appeals. These sections should include, at a minimum, the time frames for requesting an appeal at each level. They should explain that the enrollee has the right to present evidence at the ALJs level of review and the right to have someone act as a representative. It is also important to explain that the plan may attend the hearing and bring witnesses.
7	8	106	Level 5 appeals	The Level 5 appeal decision technically is not final. As with any adverse federal district court decision, the beneficiary can appeal an adverse decision further to the federal court of appeals. We suggest taking out the sentences after "A judge at the Federal District Court will review your appeal." Add in their place, "Regular federal court rules appeal to a Level 5 Appeal."
7	9	108	Possible reasons for complaints	Under information you get from our plan, add: Incorrect or inaccurate information from Member Services.
8	2.3	117	Who is eligible for a SEP	Add as an example: Our plan or an agent misrepresented our plan's benefits and features to you.
10		127	Out-of-network provider/facility	Add: We will not pay for services from an out-of-network provider or an out-of-network facility; or, if you do not use a network provider you may be required to pay more for the service.

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<b>EOC (MA-PD Template)</b>				
<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.

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1	4.1	9	Many members are required to pay other Medicare premiums	Add bullet point that refers to Section 6 for information on how to get assistance paying Part B premiums for people with limited incomes and resources.
2	1	14	Member Services	Include statements in languages used by SSA to explain how to contact member services and to get assistance in the primary language spoken
2	1	15	Coverage Decisions and Appeals	This section says plans "may" include reference to 24-hour lines. All plans should be required to include their 24-hour line for coverage decisions and appeals
2	6	23	Discussion of Medicaid	We repeat our question about the optional language for SNPs. Nevertheless, they should be required to describe the Medicaid managed care program under which they contract with a state Medicaid agency. Otherwise SNP enrollees will not have complete information about the totality of benefits to which they are entitled.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
2	8	26	SNPs and employer group insurance	We question the statement that people with employer group coverage are not eligible to enroll in dual SNPs in some states. As far as we know, no state Medicaid program precludes otherwise eligible individuals from receiving Medicaid because they have employer coverage. The only criterion for enrolling in a D-SNP is that the beneficiary be eligible for Medicaid.
3	1.1	29	Network providers	Add: You must use a network provider for us to pay for the services we cover; or, if you do not use a network provider you may be required to pay more for the service.
3	2.1, 2.3	30-32	Changing PCP/If a network provider leaves	SNPs should be required to include information about transition benefits.
4	1.2	42	Maximum out of pocket	Plans must be required to describe the services to which the OOP max applies, including dollar amount, in order for their enrollees to have accurate information about the benefit package.
4			Cost-sharing for dual eligibles	This chapter should include an explanation for duals about Medicaid coverage for their cost-sharing. It should include information on how to get reimbursed for cost-sharing that should have been paid by Medicaid, and where to send providers for information about Medicaid's reimbursement for cost-sharing.
5	3.1	65	Pharmacy discussion	The draft should explain preferred and non-preferred pharmacies for those plans that use preferred pharmacies.
5	5.2	71	Step therapy	The text should acknowledge that step therapy is sometimes used to control costs and is not used exclusively for "safer and more effective" drugs.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
5	5.2	73	transition supply	The first bullet under 2 should be included in all ANOCs, not just those for plans that offer an advance exceptions process. The CMS formulary guidance at 30.4.5 states clearly that plans must provide transition supplies to any member who has not successfully transitioned before January 1, even if advance exceptions are allowed. Many enrollees are unlikely to realize that their drug is no longer covered until they try to refill their prescription in 2010. They need to know that they have transition rights.
5	8.1	78-79	non-covered drugs	Reference to Medicaid coverage should be included for all plans, not just enhanced plans. We recommend a sentence immediately below the bullets: "If you receive Medicaid, your state Medicaid program may cover some drugs [omit prescription because some OTC drugs may be covered] not normally covered in a Medicare drug plan. Show your Medicaid card to your pharmacist. You can also contact your state Medicaid program to determine what drug coverage may be available to you."
5	10.1	80	options when leaving a skilled facility	Change the second section under Please Note: "During this time period, you can switch plans or change your coverage at any time."
6	10.4	103	late enrollment penalty appeal	This section incorrectly characterizes the appeal process for the late enrollment penalty. The plan sends the notice about LEP liability to the enrollee and is responsible for assisting the enrollee in completing the reconsideration request. But the IRE, not the plan, handles the reconsideration. See PDBM, Ch 18 at 80.7.1.2.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
7	1.1	105	reimbursement procedures	While we recognize that CMS is trying to make the process of applying for refunds simple, we are concerned that this section does not adequately inform the beneficiary of the rights and requirements of this process, which is a coverage determination. It does not tell the beneficiary about the 60 day deadline for filing, the 72 hour deadline for the plan to respond, and the 30 day deadline for the plan to reimburse. Further, item 4 should have an additional bullet to address situations when the LIS was not applied appropriately and a refund is needed. For all items, beneficiaries should be directed to the contact number for coverage determination, rather than simply told to "send a copy to us."
7	2.1	107	how to request payment	In this section as well, beneficiaries should be directed to the coverage determinations contacts rather than simply member services.
8	1.1	111	Calling Medicare	Add to last sentence in Sec. 1.1 "and tell them that you want to file a complaint."
8	1.5	113-114	Information about our plan	Add that enrollees may request information about the number of appeals.
8	1.6	115	To receive an explanation if you are denied care	This paragraph does not take into account the situations in which the plan must send a notice, even if the beneficiary does not ask for one first. The second sentence should be modified to read: In some situations you will need to ask us for a coverage determination to receive this explanation.
8	1.8	117	discrimination	First paragraph of section, after "national origin" add: "or because of the language that you speak"
9	2.1	126	Help and information from Medicare	Add after the first sentence: You should also contact Medicare if you believe that (plan) is not following the rules for dealing with your coverage decision, appeal, or complaint.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
9	4.2	128	Getting your doctor involved	The first sentence in the third bullet should read: <b>You need to get your doctor involved, especially if you want a fast or expedited decision.</b>
9	5.3	135	If your health requires it, ask for a "fast appeal"	Add a third bullet, "If your doctor tells us that your health requires a "fast appeal," we will automatically agree to give you a fast appeal." Most beneficiaries do not understand the important role of the doctor in filing an appeal.
9	5.3	137	The Independent Review Organization	Add a bullet between the 2d and 3d bullets: You have a right to give the Independent Review Organization additional information to support your appeal.
9	7.4	156	Step 1 - QIO review	Add, you have the right to give the QIO additional information.
9	9.1	169	Levels 3, 4, and 5 appeals	More information is needed about these levels of appeals. These sections should include, at a minimum, the time frames for requesting an appeal at each level. They should explain that the enrollee has the right to present evidence at the ALJs level of review and the right to have someone act as a representative. It is also important to explain that the plan may attend the hearing and bring witnesses.
9	9.1	170	Level 5 appeals	The Level 5 appeal decision technically is not final. As with any adverse federal district court decision, the beneficiary can appeal an adverse decision further to the federal court of appeals. We suggest taking out the sentences after, "A judge at the Federal District Court will review your appeal." Add in their place, "Regular federal court rules appeal to a Level 5 Appeal."

**2010 ANOC/EOC**

**Industry Comment/Response Form**

**Plan/Non-health Plan Entity:** National Senior Citizens Law Center, California Health Advocates, Center for Medicare Advocacy, and Health Assistance Partnership

**Contact Person Name:** Georgia Burke (NSCLC), David Lipschutz (CHA), Vicki Gottlich and Patricia Nemore (CMA), and Kelly Brantley (HAP)

**Email:** gburke@nsclc.org, dlipschutz@cahealthadvocates.org, VGottlich@medicareadvocacy.org, pnemore@medicareadvocacy.org, and kbrantley@hapnetwork.org

**Phone:**

**EOC (PDP Template)**

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Separate EOC for LIS beneficiaries	Page 48 of the EOC seems to indicate that an LIS specific EOC will be available from all plans. We hope that is true and, if so, request an opportunity to review the model document. A tailored ANOC is particularly important for Ch. 4 information. We urge CMS to require that plans send the LIS EOC to all beneficiaries who they know will be LIS eligible for 2010. The LIS EOC should be identified clearly on its cover as the EOC for persons receiving Extra Help. If an individual becomes eligible after the original mailing, then the plan should send the LIS document as soon as the plan is notified of the eligibility. If CMS is not planning to mandate LIS-specific EOCs, we urge the agency to do so. At the very least, this requirement should be placed on all plans that had an LIS enrollment in 2009 that was over 50%.
			Language access	On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
1	4.2	9	consequences of disenrollment	The second last paragraph, saying that those disenrolled for non payment will not be able to join another plan until the AEP is incorrect for LIS recipients. If there is not a separate LIS EOC, a sentence should be added saying that you will be able to join another plan if you receive Extra Help. For clarity, we also suggest changing the first sentence of the final paragraph of this section to say: "If we end your membership due to non-payment of premiums, you will lose your prescription drug coverage but you will still have health coverage under Original Medicare."
2	1	14	Contact lists	"How to contact us when you are making a complaint about your Part D prescription drugs" is confusing. We assume that this is meant to be the contact list for grievances, which typically do not address drugs themselves but rather plan service, timeliness, etc. Suggest changing to "About our procedures, how you were treated or other matters."
3	2.2	27	Pharmacy discussion	The draft should explain preferred and non-preferred pharmacies for those plans that use preferred pharmacies.
3		32	Step therapy	The text should acknowledge that step therapy is sometimes used to control costs and is not used exclusively for "safer and more effective" drugs.
3	5.2	34	transition supply	The first bullet under 2 should be included in all ANOCs, not just those for plans that offer an advance exceptions process. The CMS formulary guidance at 30.4.5 states clearly that plans must provide transition supplies to any member who has not successfully transitioned before January 1, even if advance exceptions are allowed. Many enrollees are unlikely to realize that their drug is no longer covered until they try to refill their prescription in 2010. They need to know that they have transition rights.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
3	7.1	40	non-covered drugs	Reference to Medicaid coverage should be included for all plans, not just enhanced plans. We recommend a sentence immediately below the bullets: "If you receive Medicaid, your state Medicaid program may cover some drugs [omit prescription because some OTC drugs may be covered] not normally covered in a Medicare drug plan. Show your Medicaid card to your pharmacist. You can also contact your state Medicaid program to determine what drug coverage may be available to you."
3	9.1	41	options when leaving a skilled facility	Change the second section under Please Note: "During this time period, you can switch plans or change your coverage at any time."
3	9.5	43	creditable coverage	We do not understand the reference to the plan sending notice of creditable coverage. To our knowledge, Part D plans do not send out creditable coverage notices.
4	10.4	66	late enrollment penalty appeal	This section incorrectly characterizes the appeal process for the late enrollment penalty. The plan sends the notice about LEP liability to the enrollee and is responsible for assisting the enrollee in completing the reconsideration request. But the IRE, not the plan, handles the reconsideration. See PDBM, Ch 18 at 80.7.1.2.

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
5	1.1	68	reimbursement procedures	While we recognize that CMS is trying to make the process of applying for refunds simple, we are concerned that this section does not adequately inform the beneficiary of the rights and requirements of this process, which is a coverage determination. It does not tell the beneficiary about the 60 day deadline for filing, the 72 hour deadline for the plan to respond, and the 30 day deadline for the plan to reimburse. Further, item 3 should have an additional bullet to address situations when the LIS was not applied appropriately and a refund is needed. For all items, beneficiaries should be directed to the contact number for coverage determination, rather than simply told to "send a copy to us."
5	2.1	69	how to request payment	In this section as well, beneficiaries should be directed to the coverage determinations contacts rather than simply member services.
6	1.1	72	Calling Medicare	Add to last sentence in Sec. 1.1 "and tell them that you want to file a complaint."
6	1.8	77	discrimination	First paragraph of section, after "national origin" add: "or because of the language that you speak"
8	3.1	115	disenrolling	For people wishing to completely disenroll from Part D, add: "If you receive Medicaid, be sure to tell us that you want to "opt out" of Part D. If you don't, you may be automatically enrolled in another plan."

# PPO

2010 ANOC/EOC				
Industry Comment/Response Form				
<b>Plan/Non-health Plan Entity:</b> National Senior Citizens Law Center, California Health Advocates, Center for Medicare Advocacy, and Health Assistance Partnership				
<b>Contact Person Name:</b> Georgia Burke (NSCLC), David Lipschutz (CHA), Vicki Gottlich and Patricia Nemore (CMA), and Kelly Brantley (HAP)				
<b>Email:</b> gburke@nsclc.org, dlipschutz@cahealthadvocates.org, VGottlich@medicareadvocacy.org, pnemore@medicareadvocacy.org, and kbrantley@hapnetwork.org				<b>Phone:</b>
<b>EOC (PPO Template)</b>				
<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.

# PPO

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Language Access	<p>On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available. Having the tagline only in English, as is done in the draft ANOC, is inadequate. In addition, each mailing should also include an insert that, in all languages that Social Security uses for its communications, stating that the mailing includes important information and that written documents or oral translations are available, along with the appropriate phone number. We noted a document on one plan's website that, with small modifications, could be adapted for this purpose. See <a href="http://www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf">www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf</a></p>

**2010 ANOC/EOC**

**Industry Comment/Response Form**

<b>Plan/Non-health Plan Entity:</b> National Senior Citizens Law Center, California Health Advocates, Center for Medicare Advocacy, and Health Assistance Partnership				
<b>Contact Person Name:</b> Georgia Burke (NSCLC), David Lipschutz (CHA), Vicki Gottlich and Patricia Nemore (CMA), and Kelly Brantley (HAP)				
<b>Email:</b> gburke@nsclc.org, dlipschutz@cahealthadvocates.org, VGottlich@medicareadvocacy.org, pnemore@medicareadvocacy.org, and kbrantley@hapnetwork.org			<b>Phone:</b>	

**EOC (PFFS Template)**

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.
			Language Access	On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available. Having the tagline only in English, as is done in the draft ANOC, is inadequate. In addition, each mailing should also include an insert that, in all languages that Social Security uses for its communications, stating that the mailing includes important information and that written documents or oral translations are available, along with the appropriate phone number. We noted a document on one plan's website that, with small modifications, could be adapted for this purpose. See <a href="http://www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf">www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf</a>

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
4	2.1	41	Prior notification requirements	The language should be mandatory. Plans that have a cost differential should be required to state: "Note that the amount of cost-sharing you pay if you do not prior notify our plan <b>will be more</b> than the cost-sharing you pay if you prior notify."
		42	Instructions	The 4th bullet says plans should include information about benefits subject to prior authorization. Plans should also include information about benefits subject to prior notification

**2010 ANOC/EOC**

**Industry Comment/Response Form**

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<b>Phone:</b>

**EOC (Cost Template)**

<i>Chapter</i>	<i>Section</i>	<i>Page #</i>	<i>Description of Issue or Comment</i>	<i>Suggested Revision or Comment</i>
			Mailing in General	We appreciate that the cover page to this mailing attempts to explain to beneficiaries the importance of the various documents and, in particular, directs beneficiaries to carefully read the ANOC. Nevertheless, we continue to believe that the sheer size of this combined mailing will confuse and intimidate beneficiaries and that the better course would be to send the ANOC (or the ANOC with the new formulary) as a separate mailing with the EOC to follow.
			Language Access	On the front cover or first page of each document--the ANOC, EOC and Formulary--there should be a tagline about the availability of translated documents. The tagline should be in all languages in which translated materials are available. Having the tagline only in English, as is done in the draft ANOC, is inadequate. In addition, each mailing should also include an insert that, in all languages that Social Security uses for its communications, stating that the mailing includes important information and that written documents or oral translations are available, along with the appropriate phone number. We noted a document on one plan's website that, with small modifications, could be adapted for this purpose. See <a href="http://www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf">www.healthnet.com/static/member/unprotected/pdfs/national/language_services.pdf</a>