November 6, 2012

The Honorable Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10003
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Agency Information Collection Activities: Proposed Collection; Comment Request (77 Fed. Reg. 174, Friday, September 7, 2012), CMS-10003-NDMCP

Dear Acting Administrator Tavenner,

On behalf of AARP, thank you for the opportunity to comment on the proposed revisions to form CMS-10003, the Notice of Denial of Medical Coverage or Payment. It is important that older Americans receive clear and concise information from their Medicare or Medicaid plans, especially if it is regarding denial of coverage or payment.

The revised CMS-10003 form combines the content of the Notice of Denial of Medical Coverage (NDMC) and the Notice of Denial of Payment (NDP) into one document. We agree that the new combined form will be less burdensome for plans to administer and has the potential to be less confusing for beneficiaries. However, we are concerned that, without clear language on the form and clear instructions to the Medicare health plans, the new form could increase confusion for beneficiaries who are eligible for both Medicare and full Medicaid benefits under a State Medicaid plan.

The revised CMS-10003 incorporates Medicaid appeal rights for individuals eligible for both Medicare and Medicaid. We commend CMS for moving towards its goal of developing an integrated denial notice to be used in the managed care setting for full dual eligible beneficiaries. Unfortunately, this form is lacking clarity and information that will help the beneficiary understand the differences between Medicare and Medicaid, as well as the differences between an appeal and State Fair Hearing.

We suggest the following modifications to CMS-10003:

Section Title: Your request was denied

- The form should contain an upfront explanation of how to understand the form itself and what information is being presented. If the beneficiary is dually eligible, the form should explicitly state that there is a difference between Medicare and Medicaid appeals

procedures. In addition, the form should state which process is being used to adjudicate the denial decision.

Section Title: You have the right to appeal our decision

- If the beneficiary is denied Medicaid benefits and is entitled to a State Fair Hearing, the form should clearly describe the differences between the health plan's appeal process and a State Fair Hearing. It should also explain why a beneficiary may want to file a health plan appeal and a State Fair Hearing concurrently (if applicable).

We believe that ensuring Medicare and Medicaid beneficiaries fully understand their rights and have complete information when making health care decisions is of the utmost importance. We appreciate CMS's work to improve the Denial of Coverage/Payment form and hope you will continue to make refinements with the beneficiary's perspective in mind. If AARP can be of further assistance, please do not hesitate to contact Andrew Scholnick of our Government Affairs staff at 202-434-3770 or ascholnick@aarp.org.

Thank you,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs