DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: May 11, 2020

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan
Director, Program Alignment Group

SUBJECT: Contract Year 2021 Models for Applicable Integrated Plans: "Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter"

The Centers for Medicare & Medicaid Services (CMS) is releasing the final contract year (CY) 2021 models for applicable integrated plans: "Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter." These final versions of the models incorporate changes based on recommendations we received from commenters who responded to our February 28, 2020 request for comment on the draft models.

Background

The Bipartisan Budget Act of 2018 directed the establishment of procedures to unify Medicare and Medicaid grievances and appeals to the extent feasible for Dual Eligible Special Needs Plans (D-SNPs) beginning in 2021. On April 16, 2019, CMS finalized rules to implement these new statutory provisions.[1] The rules at 42 CFR 422.629-634 implementing unified grievances and appeals apply only to fully integrated dual eligible special needs plans (FIDE SNPs) and highly integrated dual eligible special needs plans (HIDE SNPs) with exclusively aligned enrollment, where state policy limits the D-SNP's membership to enrollees in a Medicaid managed care plan offered by the same organization. These plans are called "applicable integrated plans" and defined at 42 CFR 422.561. As a result of these regulations, starting in 2021, this subset of D-SNPs and their partner Medicaid managed care plans will need to unify and update their appeals and grievance procedures, including the notices used to inform enrollees of their grievance and appeal rights.

On April 15, 2020, CMS released the 30-day notice for the proposed Applicable Integrated Plan Coverage Decision Letter (CMS-10716; OMB control number: 0938-New).[2] Starting in CY 2021, applicable integrated plans will be required to send this Coverage Decision Letter as a result of an integrated organization determination not resolved fully in favor of the enrollee under 42 CFR 422.631. We will advise applicable integrated plans when the Coverage Decision Letter is approved and ready for use.

[1] See 84 FR 15680 through 15844 at https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.
[2] See 85 FR 21009 https://www.govinfo.gov/content/pkg/FR-2020-04-15/pdf/2020-07884.pdf.

Also starting in CY 2021, applicable integrated plans will be required to send enrollees:

- A notice issued as a result of an extension for an integrated organization determination or integrated reconsideration or as a result of a denial of a request for an expedited integrated organization determination or integrated reconsideration under 42 CFR 422.631 and 422.633. The "Letter about Your Right to Make a Fast Complaint" provides model language for this notice.

- A notice following an integrated reconsideration not resolved fully in favor of the enrollee under 42 CFR 422.633. This notice will need to explain the enrollee's further appeal rights under both Medicare and the state Medicaid program. The "Appeal Decision Letter" provides model language for this notice.

Changes to Draft Models

Eleven plans and other stakeholders responded to our February 28, 2020 Health Plan Management System memorandum requesting feedback on the draft models of the "Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter." We made several changes to both models based on this feedback.

To better clarify how and when to use each letter, we inserted plan instructions at the beginning of both models. These instructions note that plans can insert the state-specific name for Medicaid and the plan name for member services, when applicable. Additionally, we made edits to the language in the models to improve readability and usability based on the comments we received.

In response to comments regarding the "Letter about Your Right to Make a Fast Complaint," we also:

- Inserted a more detailed plan instruction regarding which paragraph option to insert after the first paragraph;

- Provided clarifying plan instructions on the date to insert in the second paragraph option when a plan denies a request for an expedited integrated organization determination or appeal; and

- Added instructions for the reader in the section "How to make a fast complaint."

In response to comments regarding the "Appeal Decision Letter," we also:

- Included an additional language choice in the second paragraph to account for when a plan sends this model letter to deny an appeal for payment; and

- Included a language choice for when a plan suspends coverage for a service or item.

We thank commenters for their input on these models, which will be posted to https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-

Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs with related guidance and other resources. We encourage plans to contact the Medicare-Medicaid Coordination Office at MMCO_DSNPOperations@cms.hhs.gov or their account manager with any questions on these models or unified grievances and appeals processes.