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

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: November 20, 2020

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan
Director, Program Alignment Group

SUBJECT: Contract Year (CY) 2021 Notices for Applicable Integrated Plans: "Coverage Decision Letter", "Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter"

The purpose of this memorandum is to announce the release of the Coverage Decision Letter (CMS-10716) and form instructions for applicable integrated plans (as defined at 42 CFR 422.561) to use starting on January 1, 2021. We are also releasing updated versions of the Letter about Your Right to Make a Fast Complaint and Appeal Decision Letter.

Coverage Decision Letter

Applicable integrated plans must meet the unified appeals and grievance procedures defined at 42 CFR 422.629-422.634 for CY 2021. These regulations implement provisions of the Bipartisan Budget Act of 2018.

For adverse decisions on integrated organization determinations made on or after January 1, 2021, applicable integrated plans can send the Coverage Decision Letter to enrollees. This letter should only be sent as a result of an integrated organization determination for a service or item (including a Part B drug) that is not resolved fully in favor of the enrollee, as described under 42 CFR 422.631. We updated this version of the Coverage Decision Letter and form instructions based on comments received from the 30-day notice.[1] These changes were minor and mainly improvements to the plan instructions.

The Coverage Decision Letter describes the actions required by the enrollee and the enrollee's rights in the unified appeals process, including the date the determination was made, the date the determination will take effect, and language on continuation of benefits during appeal, as required under 42 CFR 422.631. These requirements are not described in the current denial notice, the Notice of Denial of Medical Coverage or Payment (CMS-10003). Therefore, applicable integrated plans' use of the Coverage Decision Letter instead of the Notice of Denial of Medical Coverage or Payment will be clearer for beneficiaries. Applicable integrated plans that use the Cover Decision Letter should not send the Notice of Denial of Medical Coverage or Payment.

The Coverage Decision Letter does not yet have an OMB control number. Applicable integrated plans' use of the form will remain voluntary, rather than legally mandatory, until the OMB control number is available. We will notify applicable integrated plans of the date that they will be *required* to send this notice and *must* no longer use Notice of Denial of Medical Coverage or

[1] See 85 FR 21009 https://www.govinfo.gov/content/pkg/FR-2020-04-15/pdf/2020-07884.pdf.

Payment (CMS-10003). We will ensure plans have adequate time to come into compliance with this requirement.

Letter about Your Right to Make a Fast Complaint and Appeal Decision Letter

We are also releasing updated model language for the following:

- Letter about Your Right to Make a Fast Complaint: Starting on January 1, 2020, applicable integrated plans may send this model notice to meet the requirements of 42 CFR 422.631 and 422.633 when the plan makes a decision on or after January 1, 2021 to 1) extend the timeframe for deciding an integrated organization determination or integrated reconsideration, or 2) deny a request for an expedited integrated organization determination or integrated reconsideration.

- Appeal Decision Letter: For integrated reconsiderations not resolved fully in favor of the enrollee and involving integrated adverse organization determinations made on or after January 1, 2020, applicable integrated plans may send this model notice to meet the requirements of 42 CFR 422.633, explaining the enrollee's further appeal rights under both Medicare and the state Medicaid program.

We have modified these model notices from the May 11, 2020[2] versions to update plan instructions. Additionally, we edited the Appeal Decision Letter to clarify that the beneficiary's right to continuation of benefits does not continue after the beneficiary loses the state Fair Hearing.

The Coverage Decision Letter, the Letter about Your Right to Make a Fast Complaint, and the Appeal Decision Letter will be available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs along 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.

[2] See the HPMS memorandum at https://www.cms.gov/files/document/dsnpcy2021appealfastcomplaintmodelsmemo.pdf