



MEDICARE-MEDICAID COORDINATION OFFICE

DATE: November 17, 2023
TO: Applicable Integrated Plans
FROM: Lindsay P. Barnette, Director
Models, Demonstrations and Analysis Group, Medicare-Medicaid Coordination Office
SUBJECT: OMB-Approved Applicable Integrated Plan Coverage Decision Letter

Purpose

The Centers for Medicare & Medicaid Services (CMS) is announcing the release of the OMB-approved coverage decision letter and form instructions for dual eligible special needs plans (D-SNPs) that are applicable integrated plans (as defined at 42 CFR 422.561)¹. Applicable integrated plans must start using the updated coverage decision letter no later than January 15, 2024.

Background

Applicable integrated plans are D-SNPs and affiliated Medicaid managed care organizations (MCOs) that must meet the unified appeals and grievances procedures defined at 42 CFR 422.629-422.634. Applicable integrated plans are required to issue a coverage decision letter as a result of an integrated organization determination under 42 CFR 422.631 when an applicable integrated plan reduces, stops, suspends, changes or denies, in whole or in part, a request for a service or item (including a Part B drug) or a request for payment of a service or item (including a Part B drug) that the enrollee has already received. Applicable integrated plans will issue the coverage decision letter in place of the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS-10003; 0938-0829) as part of requirements to unify appeals and grievance processes.

Updates

The following updates were made to the coverage decision letter:

¹ As defined at 42 CFR 422.561, an applicable integrated plan is a D-SNP with exclusively aligned enrollment, such that all D-SNP enrollees also receive Medicaid benefits under the same parent organization.

- Updated the term ‘member’ to ‘enrollee’ throughout the letter.
- Updated fields throughout the letter from “<service or item>” to “<medical service/item or Medicare Part B drug or Medicaid drug>” for consistency with language used in the Medicare Advantage and Medicare-Medicaid plan integrated denial notices.
- Added contact information to the header for states that require contact information at the top of the letter.
- In the second paragraph:
 - Added the disposition “changed” to the sentence “Our plan <denied or partially denied or reduced or stopped or suspended or changed >.” If a service is not fully approved as requested and was changed (e.g., denied an out-of-network provider but approved an in-network provider), using the term “changed” is a more appropriate disposition for this sentence.
 - Added additional instructional text for plans to use when completing this section. This paragraph now reads: [Insert description of service or item, including the amount, duration, and scope, of what the member requested (e.g., physical therapy visits 2 times per week for 1 year), and the outcome, denied, partially denied, reduced, stopped, suspended, or changed, and include the doctor or provider’s name if a particular doctor or provider requested the service or item. If a service or item request is partially denied, reduced, or changed, include specifically what was requested and what is approved (e.g., We are approving acupuncture services for 3 months instead of a full year, or We are approving moving a toilet to the south wall instead of the east wall of bathroom, or We previously approved 18 acupuncture visits per year but are now reducing the visits to only allow 10).]
 - Added a statement for plans to use when the request is a post-service payment case and the member has no liability, “Please note, you will not be billed or owe any money for this [insert as applicable: medical service/item or Part B drug or Medicaid drug].”
- In the third paragraph:
 - Added additional instructional text for plans to use when completing this section. This paragraph now reads: Our plan made this decision because [Provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision in plain language. The plain language explanation of the decision should include: (1) relevant context for the decision (e.g., if the service/item was approved for the enrollee in the past, the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now); (2) coverage information considered including Medicare and Medicaid coverage benefits; and,

(3) if applicable, information on how or why the requested service or item is not supported by the enrollee’s needs – see instructions for more information].

- In the section titled “There are two kinds of appeals,” the following statement was deleted, “Note: You can’t get a fast appeal if our plan denied payment for a service you already got.” This statement is inconsistent with our guidance in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, sections 50.1.a and 50.7.1.a that allow expedited reconsiderations for payment denials.
- Added instructional language to allow plans to remove the extensions language if a state does not allow extensions for appeals.
- In the section titled “How to keep getting your medical service/item or Part B drug or Medicaid drug during your appeal,” instructions to plans were added that make it optional to remove this section. Plans may include this section even if the decision does not relate to a service/item/drug that was approved under a previous authorization.
- The nondiscriminatory language disclaimer was added as required on CMS forms and notices.

Resources

The Coverage Decision Letter will be available at <https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements> along with related model notices, 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.