



**MEDICARE-MEDICAID COORDINATION OFFICE**

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**DATE:** December 3, 2020

**TO:** Dual Eligible Special Needs Plans

**FROM:** Sharon Donovan  
Director, Program Alignment Group

**SUBJECT:** Final Addendum to the Part C & D Enrollee Grievances,  
Organization/Coverage Determinations, and Appeals Guidance

The Centers for Medicare & Medicaid Services (CMS) previously released a proposed Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (“Part C & D Guidance”) with an opportunity for Medicare Advantage dual eligible special needs plans (D-SNPs) and other stakeholders to comment on the draft document. This Addendum will apply only to applicable integrated plans as defined in 42 CFR § 422.561. We reviewed the comments that we received and are now releasing the final Addendum. It becomes effective on January 1, 2021.

**Background**

The Bipartisan Budget Act (BBA) of 2018 directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for D-SNPs beginning in 2021. On April 16, 2019<sup>1</sup>, CMS finalized rules to implement these new statutory provisions (42 CFR §§ 422.629-634). Under these regulations, starting in 2021, a subset of D-SNPs will implement unified appeals and grievance procedures.

The rules 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" (defined in 42 CFR § 422.561). Currently, the following states and territories have contracts with D-SNPs that meet the criteria of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment: California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Puerto Rico, Tennessee, Virginia, and Wisconsin.

**Addendum for Applicable Integrated Plans**

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<sup>1</sup> See 84 FR 15696 - 15744 at <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

The Addendum supplements the Part C & D Guidance for applicable integrated plans unifying grievances and appeals procedures. This Addendum notes in corresponding sections where requirements for applicable integrated plans differ from requirements from other Medicare Advantage plans due to differences in governing regulations. The Addendum also clarifies certain requirements and processes for applicable integrated plans.

This Addendum does not apply to Medicare Part D procedures. Applicable integrated plans will continue to follow all Part D requirements in 42 CFR Part 423, including the appeal requirements for Part D benefits. For reference, the Part C & D Guidance can be found here: <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf>.

We thank reviewers for their many comments, which have informed revisions to the Addendum. In reviewing the final Addendum, applicable integrated plans should particularly note revisions and clarifications in the following areas:

- Notification procedures
- Procedures governing appointment of representative
- Handling payment requests
- Who may request an appeal
- Processing expedited requests
- Procedures and notification requirements for Medicaid-related appeals
- Dismissals
- Effectuation

In addition, below we provide additional clarification on several questions raised in the comments that may not have resulted in revisions to the Addendum:

- We received comments related to CMS program audits, including what applicable integrated plans should capture for recordkeeping purposes, and how to treat Medicaid-related cases. Applicable integrated plans should contact the CMS Program Audit mailbox for more information: [part\\_c\\_part\\_d\\_audit@cms.hhs.gov](mailto:part_c_part_d_audit@cms.hhs.gov).
- CMS reporting requirements: We received a comment asking how applicable integrated plans should treat integrated appeals for purposes of reporting requirements. We confirm that there will not be separate reporting for applicable integrated plan in 2021. For additional details on integrated appeals and Part C reporting requirements, please refer to the HPMS memo released on October 19, 2020, “CY 2021 Part C Reporting Updates for Applicable Integrated Plans and the Unified Appeals and Grievance Procedures.”
- Clinical expertise requirements for reviewing grievances: We received several comments regarding the provision in Section 30.2.a of the Addendum, which requires that someone with appropriate clinical expertise review grievances involving clinical issues. We note that this provision is contained in the regulations at 42 CFR § 422.629(k)(2), and is adapted from similar Medicaid managed care requirements at 42 CFR § 438.406(b)(2). This language is also similar to requirements for decisions on clinical issues in integrated organization determinations and reconsideration (see

42 CFR §§ 422.629(k)(3) and (4)(ii) and should be applied similarly.

- Payment cases, timeframes for decisions: We received questions about whether there are circumstances in which applicable integrated plans must expedite a request for payment. As we discussed in the Preamble to the Final Rule (see 84 FR 15,680 (April 16, 2019), page 15741),<sup>2</sup> we intentionally allow for the possibility of expedited appeals involving payment requests because of dually eligible beneficiaries' particular financial vulnerability. We expect expedited payment cases to be rare, as they are subject to the same criteria as other expedited appeals (taking the standard timeframe could jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function). Provider requests are generally unlikely to meet these requirements and thus applicable integrated plans will process them under standard timeframes. However, in the rare case where an enrollee pays for an item or service out-of-pocket and seeks reimbursement, a pressing financial need (such as rent coming due) could provide the basis to expedite an appeal.
- Written acknowledgment of integrated grievances and reconsiderations: We received a comment expressing concern about providing timely written acknowledgement in expedited cases, noting that by time the enrollee receives a mailed acknowledgement from the applicable integrated plan, the applicable integrated plan may have already issued (and verbally relayed to the enrollee) a decision, leading to enrollee confusion. While we note that written acknowledgement is required in all cases, per 42 CFR § 422.629(g), an applicable integrated plan can always provide verbal acknowledgment to an enrollee, to address timing concerns, in addition to a written acknowledgement. Further, when the applicable integrated plan resolves the expedited matter before having sent a written acknowledgement, the applicable integrated plan can include the written acknowledgement of the expedited grievance or reconsideration in the written notice informing the enrollee of the resolution.

CMS will post the Addendum at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs>, under Unified Appeals and Grievances. Please direct any questions about this memorandum or the guidance Addendum to [MMCO\\_DSNPOperations@cms.hhs.gov](mailto:MMCO_DSNPOperations@cms.hhs.gov).

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<sup>2</sup> The relevant text states “As we noted in the proposed rule (83 FR 55010–55011), Medicaid regulations at § 438.408(b)(2) do not distinguish between pre-service and post-service appeals—all appeals must be resolved within 30 calendar days. We do not believe the volume of post-service appeals, which would generally be only for payment, is high for dual eligible individuals, and we believe it is more protective of enrollees to have all integrated reconsiderations resolved in 30 calendar days, particularly given what may be significant financial needs for these individuals.” <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>