DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: October 1, 2018

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, and PACE Organizations

FROM: Jerry Mulcahy
Director

SUBJECT: Request for Review – Draft Part C & Part D Appeals Guidance

As part of an initiative to streamline the Medicare Advantage (Part C) and Prescription Drug (Part D) appeals and grievance processes, CMS has consolidated Chapter 13 of the Medicare Managed Care Manual and Chapter 18 of the Prescription Drug Benefit Manual into one comprehensive guidance document. The purpose of combining the chapters is to better align and provide a clearer, straightforward, non-repetitive interpretation of current Part C and Part D appeals policy. We have also included updated guidance based on the Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program Regulation.

We are seeking industry comment on the revised guidance, including feedback on the new structure of the guidance, its clarity, and any areas where we could make improvements. We will review all comments received and make final revisions accordingly. We are targeting January 1, 2019 as the effective date for this guidance. **Please note:** A plan's internal policies and procedures that may be impacted by the revisions in this guidance may remain the same until the final version is released.

Some general and structural changes include:

- Removed or condensed duplicative language, resulting in a significant reduction in the volume of the guidance (Chapter 13 & 18 was a total of 211 pages. Merged guidance is 100 pages).
- Simple, universal terminology is used where guidance is applicable to both Part C & Part D.
- Guidance applicable to only Part C or Part D, is clearly separated and easily identifiable.

- Sections were reorganized to align with the order of the appeals process, as well as make it easier to reference important guidance, such as timeframes or notification requirements.
- Appendix consists of Part C and Part D appeals charts and includes a list of links to CMS regulations, mailboxes, notices and forms.
- Updates to reflect recent regulatory changes that include the following:
    - Tiering Exceptions policy (Part D).
    - Part D payment timeframes will provide plans and IREs additional time to issue appeal decisions.
    - Part C plans do not have to notify enrollees if their case is forwarded to the IRE.
    - Guidance related to at-risk determinations made under a plan sponsor's drug management program (Part D).
- Changes to align Part C and Part D policies, such as:
    - Permitting plans to not forward untimely cases to the IRE when approval is made within 24 hours of the expiration of the adjudication timeframe.
    - Ability to satisfy verbal notification requirements by making and documenting good faith attempts and following up with written notice.
    - Clarification to guidance, including but not limited to the following areas: Conducting outreach for additional information.
    - Verbal requests made by an individual on behalf of the enrollee.
    - Withdrawals and dismissals.
    - When a request is considered received and when timeframes begin.
    - Notifying enrollees of favorable determinations.
    - When to use the reopening process.
    - When to issue an IDN or an EOB for Part C denials.
    - Tolling the start of the adjudication timeframe for exceptions requests (Part D).

To submit comments, please send to Part_C_Appeals@cms.hhs.gov with "Part C and Part D Appeals Guidance" in the subject line. Submit any comments intended for consideration by close of business Monday, October 22, 2018. Comments received after this date will be reviewed for future revisions of the guidance.