Summary of Comments and Responses for 60-day PRA Coverage Decision Letter (CDL)

Comment	Response
A health plan commented that the draft CDL does not include a space to insert the enrollee's address block and is requesting to add it to show through a window envelope.	We appreciate the comment but decline to include an address block on the coverage decision letter (CDL). The Medicare Advantage (MA) and Medicare-Medicaid Plan (MMP) integrated denial notices (IDN) similarly do not include a space for an address block on the notice. Additionally, adding an address block pushes key content below the first page that is important for overall understanding of the CDL.
A state Medicaid agency suggested the new information added below the header that is currently centered should be aligned to the left for better readability. It also recommended rewording the first paragraph so that it is in plain language. Finally, this commenter suggested adding information into the section on continuation of benefits pending appeal to include information on paying for services if the appeal is adverse to the enrollee.	We agree the text at the top of the CDL should be left-aligned so that it is easier to read and have updated the language accordingly. We also appreciate the comment on using plain language in the first paragraph. We conducted extensive beneficiary testing of the CDL and drafted it based on findings and feedback from enrollees and their caregivers. Thus, at this time, we decline to make broad changes to the language in the CDL. We welcome commenters to suggest alternatives to certain words or phrases for consideration. The last comment suggested that we add language in the continuation of benefits section to notify an enrollee they may have to pay for services if their appeal is adverse. We appreciate the comment; however, applicable integrated plans (AIP) and states may not pursue recovery for costs of services furnished during the integrated reconsideration per 42 CFR 422.632(d)(1). We decline adding the suggested language to the CDL.
Multiple health plans suggested changing the fields that read "<service or item>" to "<service/item>" where displayed through the CDL.	We accept this edit and will change language throughout the CDL to state "medical service/item." This is also consistent with language used in the MA and MMP IDNs.
A health plan suggested updating language in a few sections of the CDL to reduce plan burden and enrollee confusion. On page 1, the commenter suggested combining the sentences "Our plan <denied	We appreciate the comments and acknowledge the concerns but will maintain the current language. The language on page 1 includes a field for the service or item that is denied, reduced, stopped,

or partially denied or reduced or stopped or suspended or changed > [Insert if applicable: payment for] the <service or item> listed below:" and "Our plan made this decision because:" On page 2, the commenter noted the administrative burden to include specific dates to appeal by instead of stating they must appeal within 60 days and was concerned this would cause data entry errors. The commenter also suggested replacing language in the continuation of benefits section and remove the fields where a specific date is filled in and replace it with 10 calendar days or remove it altogether.	suspended or changed and a separate field to describe why it was denied. Those are distinct fields that should remain separate so the enrollee can clearly understand what was denied and why. The requirement to include the exact date to appeal by in the CDL has been included in the previous version, so this is not a new burden on plans. Plans must already calculate the deadline for receipt of an appeal for internal record-keeping and including this exact date is an important element of the CDL to reduce enrollee confusion. We have bracketed the continuation of benefits section so that plans have the option to remove this language if the denial is not related to a previously approved medical service/item. However, if the denial is related to a previously approved service, including the exact date to request a continuation of benefits is an important element to reduce enrollee confusion.
Multiple health plans requested to be allowed to keep the section titled "How to keep getting your medical service/item during your appeal" that is newly bracketed. The comments stated removing this section would result in unnecessary customization and required costly reconfiguration in their system. Commenters also had concerns with version control and staff inappropriately removing this paragraph.	We appreciate the comments and agree keeping this paragraph in the CDL is permissible if it causes undue burden to remove it or there are concerns with version control. We have updated the instructions in the CDL to make it optional for plans to remove the language.
An advocacy organization appreciated language added to the CDL that improved readability and reduced confusion for the enrollee. They expressed concern that new language for post-service cases was confusing and needed further explanation: "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]." It also suggested that CMS add language regarding continuing of care during appeal to the beginning of the CDL.	We appreciate the feedback on the language added to improve readability and reduce confusion. We agree that ensuring understanding of the content is an important element of the CDL. We welcome the comment but will maintain the current language for payment cases where the enrollee has no liability. The CDL is only used by AIPs. The language in the Medicare fee-for-service advance beneficiary notice is not applicable to AIP enrollees because they are full-benefit dually eligible individuals who cannot be separately

	billed by providers. We decline to include the requested language in the CDL so that it does not cause confusion for enrollees. We also appreciate the comment to add language at the beginning of the CDL regarding continuing benefits during an appeal. We have added the following sentence to refer the enrollee to the section later on in the CDL: “See the ‘How to keep getting your <medical service/item> during your appeal’ section later in this CDL for information about continuing to receive your <medical service/item> during your appeal.”
A health plan suggested moving language about stopping, suspending, reducing previously approved services to after the second paragraph. The plan inquired about the new disposition “changed” that was added to the CDL and how to identify those cases for reporting purposes. The plan also inquired about the language that states “You can’t get a fast appeal if our plan denied payment for a service you already got” when enrollees can request a fast appeal for payment denials.	We appreciate the suggestion to move language regarding stopping, suspending, reducing previously approved services to after the second paragraph. However, we decline to move the language as it is currently included above the information on appeal rights. Based on findings from testing of this form with enrollees and their caregivers, we have deliberately sequenced the information in the form to align with the sequence of steps in the appeals process. We refer plans to the Medicare Part C Reporting Requirements and Technical Specifications to review the requirements for reporting Medicare Part C decisions. Requests that are changed would be in the partially denied or adverse category for reporting.[1] We welcome the comment on language in the CDL that states “You can’t get a fast appeal if our plan denied payment for a service you already got” that contradicts our policy guidance. We have removed this language as it is not consistent with our policy in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans[2] that does allow fast appeals for payment denials. Thank you for bringing this to our attention.

[1] Medicare Part C reporting requirements can be found on CMS’ website: https://www.cms.gov/medicare/health-plans/healthplansgeninfo/reportingrequirements.

[2] The Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans can be found on CMS’ website: https://www.cms.gov/files/document/dsnpartscdgrievancesdeterminationsappealsguidanceaddendum.pdf.

An advocacy organization appreciated the improvements to the CDL that make it more readable and navigable. It also encouraged CMS to conduct consumer testing when possible to ensure the legal information in letters is presented in a manner that is easy to read and navigate.	We appreciate the feedback on the language added that makes the CDL more readable and navigable. We also appreciate the comment on conducting consumer testing and agree it is important to engage with enrollees to ensure the CDL is understandable to those who will receive it.
A health plan inquired whether the CDL could be adjusted for coverage decisions for multiple services or items. On the first page, it commented that including the outcome twice was redundant with the paragraph that informs the enrollee about the decision made. The health plan also questioned whether it could provide the information in a grid format instead of a narrative to ensure consistency and ease of enrollee understanding. The plan suggested in the section "What happens next" to include "after the appeal" in the header so that it is clearer that section is referring to after the appeal.	Plans are permitted to include multiple coverage decisions in the CDL as long as the outcome for each decision is clear. We appreciate the comment that the outcome is repeated in the second paragraph of the CDL, however, we decline changing the italicized instructions to plans. This language includes suggested content to include when providing information on the outcome to ensure the enrollee understands the decision. Plans may provide the outcome in a grid format as long as it includes all required information and is clear to the enrollee. We also suggest the grid does not take up too much space causing the information below it to be pushed down significantly in the CDL. We appreciate the comment on renaming the section "What happens next" to include "after the appeal" at the end of the header. We are not accepting this change since the line under the title starts by stating "After the appeal" so it is already clear to the reader what that section discusses.
A state Medicaid agency supported the new elements incorporated into the updated CDL that make it clearer and more understandable. It especially appreciated instructional text in the introduction of the CDL and plain language explanations of the decision. The state Medicaid agency encouraged CMS to require plans attest to using plain language throughout the CDL. The commenter included recommendations to strengthen areas in the CDL by requiring plans to include: key contact information at the top of the CDL, the date of decision field, and the statement "Please note, you will not be billed or owe any money for	We thank the commenter for the feedback that the language added makes the CDL clearer and more understandable. We agree that using plain language is important so that enrollees understand the content of the CDL. The instructions that accompany the CDL state any free text insertions should be written in a way that is understandable by a layperson and be in plain language. We decline to require plans attest to using plain language as we do not currently have a mechanism to maintain the attestations, however, CMS does review CDLs during Medicare program audits to ensure they are understandable to enrollees.

this [insert as applicable: medical service/item or Part B drug or Medicaid drug].” In addition, the state Medicaid agency recommended additional items that were not addressed in the updated CDL. These include: changing the phrasing “service or item” to “services, supports, or items,” adding language you must appeal to plan name by (date), adding an online option for enrollees and allow for email submission of appeals, specifying Medicaid drugs and over the counter medications are in scope for the CDL, and clarifying in the instructions document that Part B and Medicaid drugs should be included in the CDL.	We appreciate the recommendations to strengthen the CDL by requiring the key contact information, date of decision field, and the note regarding not being billed for services received. States may require the contact information and date of decision via the state Medicaid agency contract (SMAC). The new statement added “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]” is a required element for post-service payment cases. We decline updating fields to state “services, supports, or items,” however, we have updated the CDL fields to state “medical service/item” as this language is consistent with terms used in the MA and MMP IDNs. We agree and thank the commenter for the suggestion to make it clearer where the appeal is filed. As such, we updated the CDL to read “You must appeal **to our plan** by [Insert specific appeal filing deadline date in month, date, year format – 60 calendar days from date of letter. Insert deadline date in bold text].” We appreciate the comment to add online and email options for enrollees to file an appeal. Plans may allow appeals to be filed by email, however, CMS does not have a requirement for plans to have online options. AIPs must accept integrated appeals filed orally and in writing. We have added language throughout the CDL that clarifies the CDL should also be issued for denied Medicare Part B drugs and Medicaid drugs. The fields have been updated to allow plans to choose the appropriate language “medical service/item or Part B drug or Medicaid drug” based on the denial. We appreciate the recommendation to include information in the instructions that Part B and Medicaid drugs should be included in the CDL and have made that update.

A health plan asked why CMS updated the term “member” to “enrollee” throughout the CDL. In the header on page 1, it raised concern with the contact information added under the title of the CDL since it was confusing and drew attention away from the CDL’s intent. The health plan also noted concern about adding the optional field “date of decision” in the header section. In the second paragraph, the health plan identified that disposition ‘changed’ was added, but it would not use that determination. It also highlighted that there was a lot of information added into the paragraph that discusses the outcome of the medical service/item. The health plan pointed out that the information was too much to include in one paragraph and their current process is to send a separate approval notice for any services/items that were approved. In the third paragraph, the health plan discussed the additional information included to help clarify for the enrollee why the plan made the decision. The health plan conveyed concerned that it may not have the historical information needed for previously approved services and this inclusion would make the CDL too long.	We appreciate the feedback on the CDL. It was updated to use the term ‘enrollee’ as part of a CMS-wide effort to standardize the use of the term in materials. In the header section of the CDL, the contact information was included so that enrollees can easily find the contact information for the health plan. This field is optional unless the state communicates via the SMAC that the field is required. The ‘date of decision’ field in the header section is also an optional field unless the state requires it via the SMAC. In the second paragraph, plans need to chose the term that best describes the action taken. The disposition ‘changed’ does not need to be selected if not appropriate. The information added to this paragraph is to give examples of language that can be utilized to describe the outcome. Plans can use their discretion to include language that is appropriate for the outcome in each case. In the third paragraph, plans should include a description of medical service/item, including the amount, duration, and scope, of what the enrollee requested, and the outcome. Plans should include enough information so that the enrollee understands the full outcome of their request.
A health plan recommended CMS allow plans to suppress or remove fast appeal language throughout the CDL for post-service/payment cases. Fast appeal language is included in sections titled “There are two kinds of appeals” and “How to appeal” and they would like to be able to remove the language so it is not confusing to enrollees.	CMS appreciates the comment but will maintain the current language regarding fast appeals. Enrollees or their representatives are permitted to request a fast appeal for a payment request. AIPs should apply the same process to assess a request to expedite a payment request as they do to assess requests to expedite non-payment cases. The standard for deciding whether to expedite a payment request is the same as for non-payment cases (i.e., the standard timeframe could seriously jeopardize the life or health or the enrollee, or their ability to regain maximum function, in accordance with 42 CFR 422.631(c) and 422.633(e)). Additionally, we have removed the statement “Note: You can’t get a fast appeal if our plan denied payment for a service you already got”

	from the section "There are two kinds of appeals." This statement is not consistent with our policy in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans that allows enrollees to request fast appeals for payment denials.