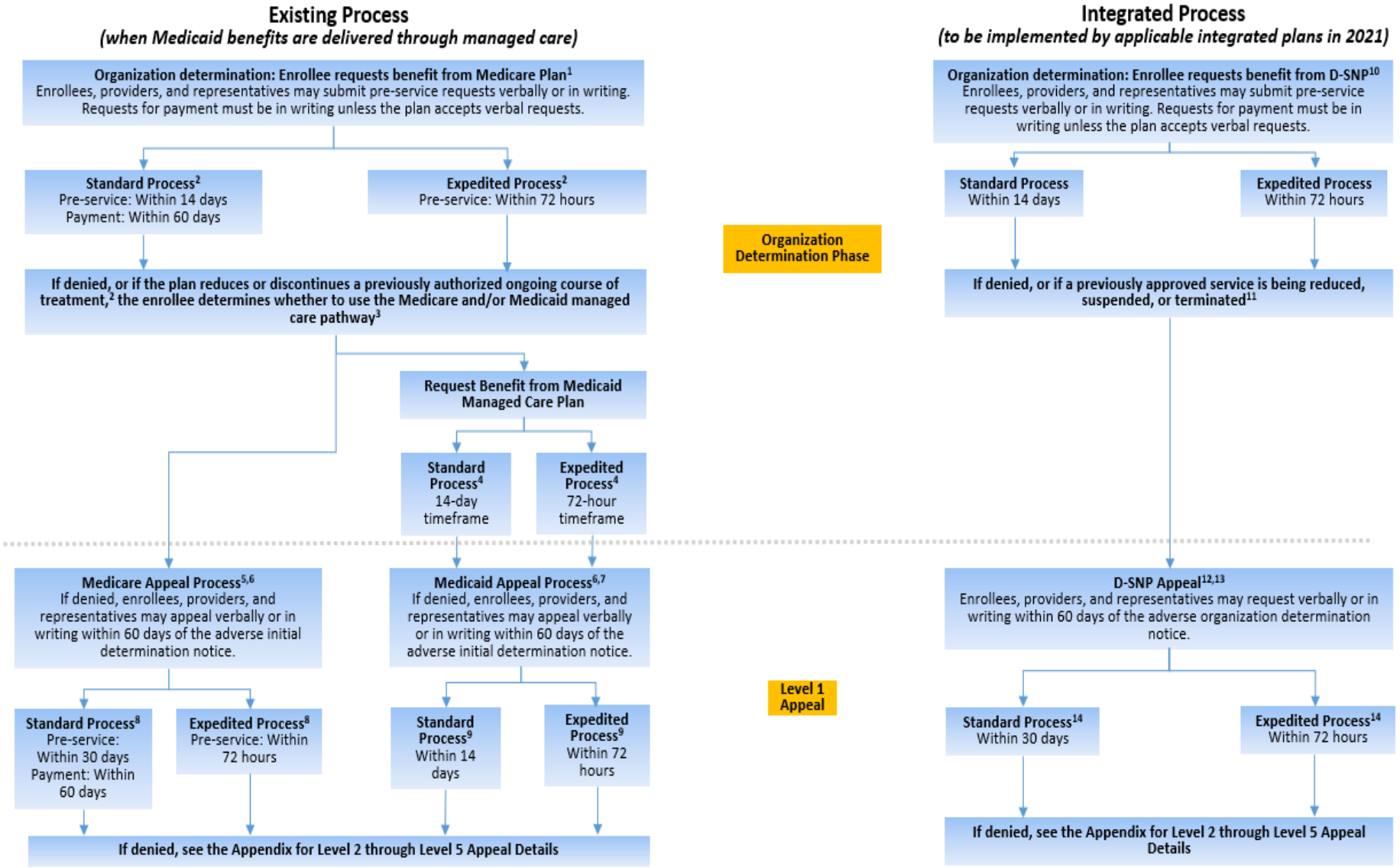
Appeals and Grievances: Comparisons of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans

The following flowcharts are designed to help states, health plans, and other stakeholders understand the differences between existing Medicare and Medicaid appeal and grievance processes and the new integrated appeal and grievance processes established at 42 CFR Part 422 Subpart M for applicable integrated plans, as defined at 42 CFR 422.561 and amended by 87 FR 27780.

Appeals: Comparison of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans



Appeal Process Endnotes

[1] See sections 40.6 - 40.8 of the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for more details on organization determinations.

[2] The Medicare plan must process Medicare pre-service requests within 14 calendar days, and expedited requests within 72 hours, with a possible 14-day extension. Plans must process payment requests within 30 days. See section 40.10 of the Part C & D Guidance for more details. If the Medicare plan makes an organization determination to reduce or discontinue a previously authorized ongoing course of treatment, or deny payment, it must provide written notice under 42 CFR 422.568(d), and comply with notice requirements at 42 CFR 422.568(e). See section 40.1 and 40.12.1 of the Part C & D Guidance for more details. Effective January 1, 2020, shorter timeframes apply to Part B drug requests.

[3] In the existing process, enrollees determine whether to use the Medicare pathway, the Medicaid pathway, or both. If a member is enrolled in Fee-for-Service (FFS) Medicaid, FFS Medicaid appeals processes apply.

[4] Plans must process Medicaid standard authorization decisions and provide notice as expeditiously as the enrollee's condition requires and within state-established timeframes that may not exceed 14 calendar days, with a possible extension of up to 14 additional calendar days. For cases in which a provider indicates, or the plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the plan must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. The plan may extend the 72-hour period by up to 14 calendar days. See 42 CFR 438.210(d) for more details.

[5] If the Medicare plan denies a benefit that is covered by both Medicare and Medicaid, an enrollee may initiate an appeal with the Medicare plan at the same time they request the benefit from their Medicaid plan. Enrollees, their representatives, and providers may request a Medicare standard or expedited appeal. The same parties may request a payment appeal, except that only non-contract providers may do so. Plans must accept written standard appeals and may accept verbal standard appeals. Plans must accept written and verbal expedited appeals. See sections 50.1 and 50.2 of the Part C & D Guidance for more details.

[6] The Medicaid plan must continue the enrollee's benefits if: (1) the enrollee files the request for an appeal timely in accordance with 42 CFR 438.402(c)(1)(ii) and (c)(2)(ii); (2) the appeal involves the termination, suspension, or reduction of previously authorized services; (3) the services were ordered by an authorized provider; (4) the period covered by the original authorization has not expired; and (5) the enrollee timely files for continuation of benefits. The enrollee must file for continuation of benefits on or before the later of the following: (1) within 10 calendar days of the plan sending the notice of adverse benefit determination; or (2) the intended effective date of the plan's proposed adverse benefit determination. See 42 CFR 438.420 for more details. Medicare benefit appeals do not include a right to continuation of benefits.

[7] If a Medicaid plan denies a requested benefit, enrollees, their representatives, and providers may file Medicaid appeals within 60 calendar days. See 42 CFR 438.402 for more details.

[8] Plans must process Medicare standard appeals within 30 days, and expedited appeals within 72 hours, with a possible extension of 14 days. Plans must process payment appeals within 60 days. See section 50.2 of the Part C & D Guidance for more details. Effective January 1, 2020, shorter timeframes apply to Part B drug appeals.

[9] Plans must resolve Medicaid standard appeals as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 30 calendar days. Plans must resolve expedited appeals as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 72 hours. See 42 CFR 438.408 for more details.

[10] Enrollees, their representatives, and providers may request a standard integrated organization determination for Medicare or Medicaid benefits verbally or in writing. Requests for payment must be in writing unless the plan accepts verbal payment requests. Enrollees, their representatives, and providers may request an expedited integrated organization determination verbally or in writing. See 42 CFR 422.631(b) and (c) for more details.

[11] For standard integrated organization determinations, in cases where a previously approved service is being reduced, suspended, or terminated, the plan must send an enrollee a written notice of any adverse decision at least ten days before the date of action. See 42 CFR 422.631(d)(1) and (d)(2) for more details.

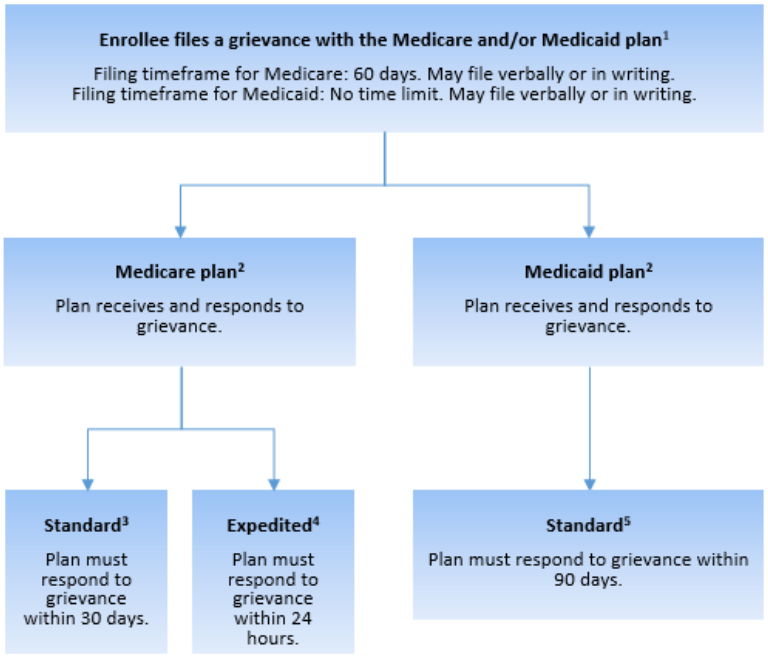
[12] An enrollee may file an integrated appeal either verbally or in writing and has 60 calendar days from the date on the adverse organization determination notice to file a request for an integrated appeal with the plan. See 42 CFR 422.633(d) for more details.

[13] The plan must continue the enrollee's benefits if: (1) the enrollee files the request for an integrated appeal timely in accordance with 42 CFR 422.633(e); (2) the integrated appeal involves the termination, suspension, or reduction of previously authorized services; (3) the services were ordered by an authorized provider; (4) the period covered by the original authorization has not expired; and (5) the enrollee timely files for continuation of benefits. The enrollee must file for continuation of benefits on or before the later of the following: (1) within 10 calendar days of the plan sending the notice of adverse integrated organization determination; or (2) the intended effective date of the plan's proposed adverse integrated organization determination. See 42 CFR 422.632 for more details.

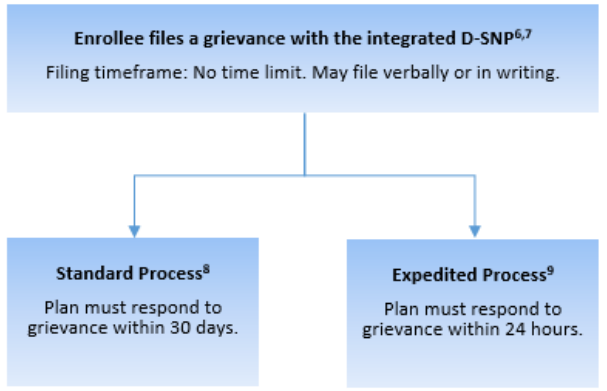
[14] The plan must resolve integrated appeals as expeditiously as the enrollee's health condition requires, but no longer than 30 calendar days from the date of receipt of the request for the appeal. The plan must resolve expedited appeals as expeditiously as the enrollee's health condition requires but no later than within 72 hours of receipt for the appeals. 42 CFR 422.633(f) for more details. For Part B drug requests and appeals, the new, shorter Medicare Advantage timeframes apply.

Grievances: Comparison of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans

Existing Process
(when Medicaid benefits are delivered through managed care)



Integrated Process
(to be implemented by applicable integrated plans in 2021)



Grievance Process Endnotes

[1] For Medicare grievances, the enrollee must file a grievance no later than 60 days after the event that precipitates the grievance. The enrollee may submit the grievance verbally or in writing. For Medicaid grievances, the enrollee may file a grievance at any time, and, as determined by the state, either with the state or the plan. The enrollee may file a grievance verbally or in writing. See Section 30.2 of the Part C & D Guidance and 42 CFR 438.402 for more details.

[2] For Medicare grievances made in writing, the plan's response must be in writing, address all issues raised in the grievance, and be written in a manner that is understandable to the enrollee. For grievances received verbally, the response may be verbal or in writing, unless the enrollee specifically requests a written response or if the grievance raises a quality of care issue. See Section 30.2.1 of the Part C & D Guidance for more details. For Medicaid grievances, the state must establish the method that the plan will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. See 42 CFR 438.408 for more details.

[3] The plan must complete an investigation as expeditiously as the case requires, based on the enrollee's heath status, but no later than 30 days after receipt of the grievance. The plan may take a 14-day extension if the enrollee requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. See Section 30.2 of the Part C & D Guidance for more details. See procedures for quality of care grievances in Section 30.3 of the Part C & D Guidance.

[4] The plan must complete an investigation as expeditiously as the case requires, based on the enrollee's heath status, and within 24 hours of receipt of the grievance. The plan may take a 14-day extension if the enrollee requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. See Section 30.2 of the Part C & D Guidance for more details. See procedures for quality of care grievances in Section 30.3 of the Part C & D Guidance.

[5] The state establishes the timeframe for resolution of a grievance and notice to the affected parties. The timeframe may not exceed 90 calendar days from the day the plan receives the grievance. The plan may extend this timeframe by up to 14 calendar days if the enrollee requests the extension, or if the plan shows (to the satisfaction of the state agency, upon request) that there is need for additional information and how the delay is in the enrollee's interest. See 42 CFR 438.408 for more details. There is no expedited grievance process set out in Medicaid managed care regulations.

[6] An enrollee may file an integrated grievance at any time verbally or in writing with the plan, or with the state for a grievance related to a Medicaid benefit, if the state has a process for accepting Medicaid grievances. See 42 CFR 422.630(b) and (c) for more details.

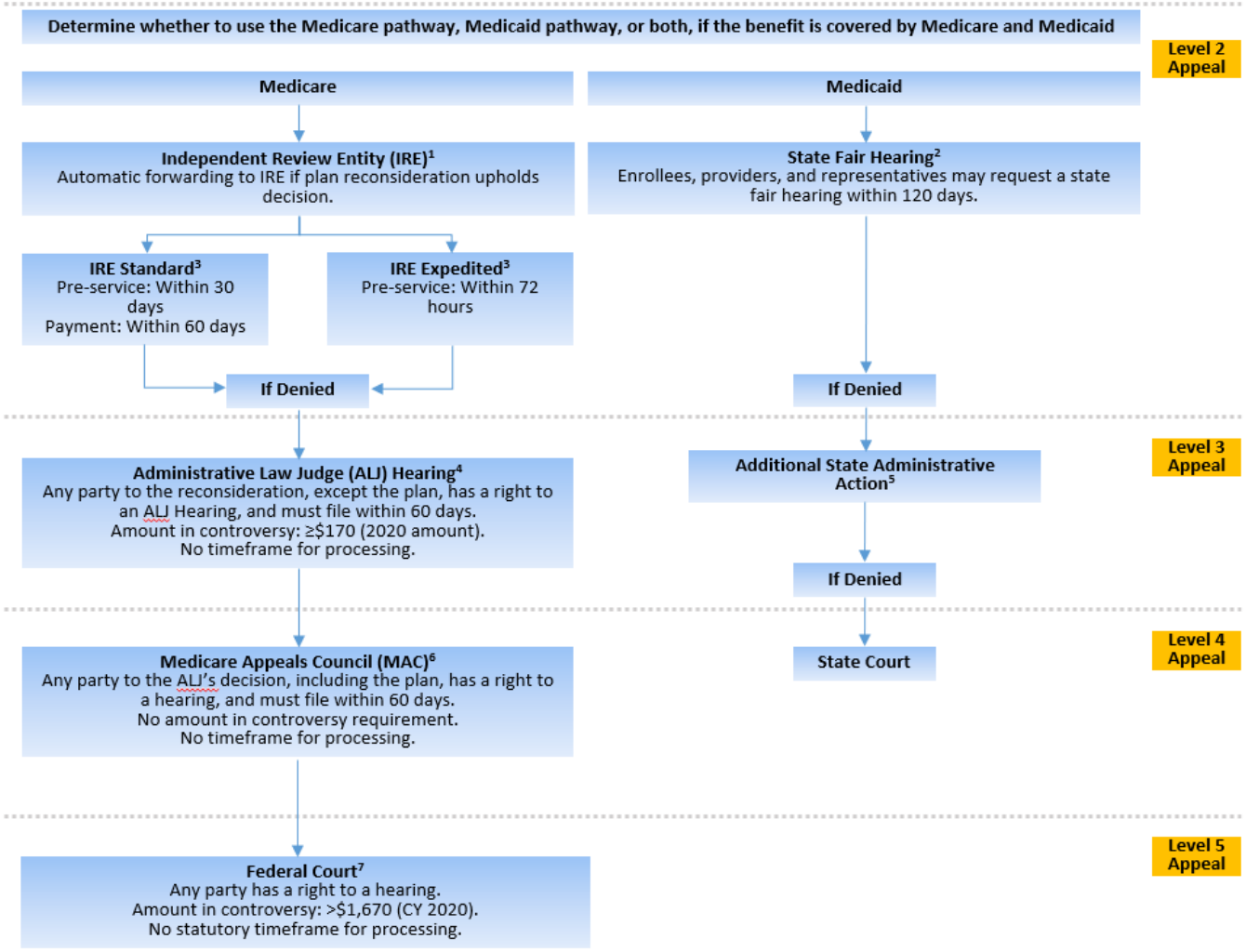
[7] These grievance processes apply to applicable integrated plans beginning on January 1, 2021. Applicable integrated plans are D-SNPs with exclusively aligned enrollment, where one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees through the D-SNP and the affiliated Medicaid managed care plan.

[8] The plan must resolve standard integrated grievances as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 calendar days from the date it receives the integrated grievance. The plan may extend the timeframe for resolving the integrated grievance by 14 calendar days if the

enrollee requests an extension or if the applicable integrated plan justifies the need for additional information and documents how the delay is in the interest of the enrollee. For more details, including for grievances related to quality of care, see 42 CFR 422.630(e).

[9] The plan must respond to an enrollee's grievance within 24 hours if the grievance involves (1) the plan's decision to invoke an extension relating to an integrated organization determination or integrated reconsideration; or (2) a refusal to grant an enrollee's request for an expedited integrated organization determination under 42 CFR 422.631 or an expedited integrated reconsideration under 422.633. For more details, see 42 CFR 422.630(d).

Appendix: Level 2 through Level 5 Appeal



Appendix Endnotes

[1] All partially favorable or adverse Medicare appeal decisions are automatically forwarded to the IRE. See section 60.1 of the Part C & D Guidance for more details.

[2] Enrollees may request a Medicaid state fair hearing after receiving notice that the plan is upholding its adverse decision. The enrollee must request a state fair hearing within 120 calendar days. See 42 CFR 438.408(f) for more details.

[3] The IRE must process standard appeals within 30 days and standard payment appeals within 60 days. The IRE must process expedited appeals within 72 hours. See section 60.3 of the Part C & D Guidance for more details.

[4] Any party to the Medicare appeal, except the plan, has a right to request an ALJ hearing. See section 70.1 of the Part C & D Guidance for more details. See section 70.2 for amount in controversy details.

[5] Varies by state. Some states allow beneficiaries to appeal directly to state court.

[6] Any party to the ALJ's decision, including the plan, can request a MAC review. The MAC level has no amount in controversy requirement. See section 70.1 of the Part C & D Guidance for more details.

[7] Any party, including the plan, may appeal to federal court. See section 70.2 of the Part C & D Guidance for amount in controversy details.