Unified Appeal and Grievance Processes for States with Applicable Integrated Plans (AIPs)

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Until 2021, full-benefit dually eligible individuals enrolled in Medicare Advantage dual eligible special needs plans (D-SNPs) had to navigate separate—and in some cases conflicting—Medicare and Medicaid appeal and grievance processes. Prior to 2021, even if a dually eligible individual was enrolled in a D-SNP and a Medicaid managed care plan offered by the same parent organization ("affiliated plans"), they would have to use separate processes to submit an appeal through their D-SNP, Medicaid plan, or both (and determine which process to use based on whether a benefit would normally be covered by Medicare, Medicaid, or both). Those disparate processes also differed in certain respects, such as the timeframes in which the plan must resolve an enrollee's grievance.

ABOUT THIS TOOL

Appeals and grievances help safeguard access, quality, and enrollee satisfaction for people enrolled in Medicaid managed care and Medicare Advantage plans, including D-SNPs. Specifically, an enrollee can (1) appeal their plan's decision to deny, stop, or reduce coverage for a particular health care service and (2) file a grievance about any dissatisfaction with their healthcare experience.

This technical assistance tool describes the unified Medicare and Medicaid appeal and grievance processes for dually eligible individuals enrolled in applicable integrated plans (AIPs). It also describes states' roles and options in those unified appeal and grievance processes, such as adding requirements to D-SNP contracts and incorporating state-specific language into certain unified appeal and grievance letters.

To remedy this, the Centers for Medicare & Medicaid Services (CMS) now requires D-SNPs that qualify as applicable integrated plans (AIPs)—meaning they operate with exclusively aligned enrollment and cover certain Medicaid benefits through the D-SNP or the D-SNP's affiliated Medicaid managed care plan—to use the unified appeal and grievance processes detailed at 42 CFR §§422.629 – 422.634.[1] These plans must offer integrated plan-level appeals and grievances for all Medicare and Medicaid benefits (other than Medicare Part D prescription drug benefits). These integrated processes are designed to resolve misalignments between Medicare and Medicaid plan-level processes and streamline experiences for plans.[2]

This technical assistance tool summarizes the federal unified appeal and grievance requirements for states that contract with AIPs. It also provides information for these states on (1) requiring AIPs to use the unified appeal and grievance processes via their state Medicaid agency contracts (SMACs), (2) requiring AIPs to use shorter appeal and grievance timeframes and/or more protective requirements than those included in federal rules, (3) requiring AIPs to use state-specific language in certain unified appeal and grievance letters, (4) conducting state-specific training for plans, (5) overseeing D-SNP compliance with state-specific unified appeal and grievance requirements, and (6) using appeal and grievance data to monitor and improve D-SNP performance.

Federal Rules for AIP Unified Appeal and Grievance Processes

CMS requires AIPs (see Box 1) to use the unified, plan-level appeal and grievance processes described at 42 CFR §§422.629 – 422.634 for all Medicare and Medicaid benefits, except for Medicare Part D prescription drug benefits. For Part D drugs, AIPs follow the Part D requirements at 42 CFR §423 Subpart M and use Part D notices.[6,7] Medicare Part B drugs are included in the unified appeal and grievance processes but are sometimes subject to different notice and timeframe requirements described at 42 CFR §§422.568(b)(3), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), and 422.590(e)(2) rather than those described at 42 CFR §§422.629 – 422.634. See Appendix A for details.

Box 1: AIPs and exclusively aligned enrollment

AIPs are:

1. Fully or highly integrated dual eligible special needs plans (FIDE SNPs or HIDE SNPs) operating with exclusively aligned enrollment; or
2. Coordination-only (CO) D-SNPs with exclusively aligned enrollment that cover (through the D-SNP or through an affiliated Medicaid managed care plan) Medicaid primary and acute care benefits, Medicare cost sharing, and at least one of the following additional Medicaid benefits: home health services; medical supplies, equipment and appliances, or nursing facility services.

Exclusively aligned enrollment occurs when a state's contract with a D-SNP limits D-SNP enrollment to only full-benefit dually eligible individuals who receive Medicaid benefits from the D-SNP or a Medicaid managed care plan offered by the same parent organization as the D-SNP.

More information about AIPs and exclusively aligned enrollment is available in ICRC's glossary of terms,[3] tip sheet on the different types of D-SNPs,[4] and resources on exclusively aligned enrollment.[5]

D-SNPs that do not qualify as AIPs use the standard Medicare Advantage and Part D appeal and grievance processes described at 42 CFR §422.560 – 422.626 and §423 Subpart M, which are separate from the processes used for coverage of Medicaid benefits. ICRC's appeal and grievance flowcharts explain the separate Medicare Advantage processes and compare them to the unified processes used by AIPs.[8]

Unified Appeal Process

The unified appeal process establishes a single, streamlined pathway at the plan level for appeals related to Medicare and Medicaid benefits. The process begins when (1) an AIP enrollee, their authorized representative, or a provider requests coverage or payment for a benefit or (2) an AIP terminates, suspends, or reduces a previously authorized benefit.[9] AIPs must make these decisions—known as "organization determinations"—in an integrated fashion (meaning the AIP must consider applicable Medicare and Medicaid coverage options when making the determination). AIPs must issue notices of adverse organization determinations:

1. At least 10 days before the effective date of a benefit termination, suspension, or reduction for a benefit that was previously approved;[10]
2. Within 14 calendar days after receiving a request for a benefit that *is not* subject to prior authorization rules;[11] and
3. Within 7 calendar days after receiving a request for a benefit that *is* subject to prior authorization rules.[12]

For expedited requests, AIPs must respond no later than 72 hours after receiving the request.[13]

If the plan denies a request or reduces, suspends, or terminates a previously authorized benefit, the enrollee, a provider, or an authorized representative may file a request for an integrated appeal (also called an integrated reconsideration). These requests may be filed with the plan orally or in writing within 60 calendar days of receipt of the plan's notice of the adverse benefit decision.[14] The plan must resolve integrated appeals as expeditiously as the enrollee's health condition requires but no later than 30 calendar days and provide notice of its appeal decision if the enrollee uses the standard appeal process. If the enrollee requests (and qualifies to use) the expedited appeal process, the plan must issue a decision within 72 hours.[15]

Plans can extend their timeframe for making an integrated appeal decision by 14 calendar days if (1) the enrollee requests an extension or (2) the plan shows that the delay is in the enrollee's best interest, the plan needs additional information, and there is a reasonable likelihood that the information could lead to a favorable decision for the enrollee.[16] The plan must make reasonable efforts to promptly notify the enrollee orally of the delay. Within two calendar days, the plan must also notify the enrollee in writing of the reason for the delay and explain that they can file a grievance if they disagree with the decision to delay.

If the plan's appeal decision is not in favor of the enrollee, the plan must explain in its notice of appeal decision (1) the next level of appeal under the Medicare and Medicaid programs, (2) what steps the enrollee must take to pursue the next level of appeal under each program, and (3) other information relevant to the appeal, such as how the enrollee can obtain assistance in pursuing the next level of appeal under both Medicare and Medicaid.[17] Enrollees may request to continue receiving the applicable benefit(s) during the plan-level appeal process—without risking having to pay for those services if they lose the appeal—if they file their appeal and request for continuation of benefits timely, the services subject to the appeal were previously authorized and ordered by an authorized provider, and the period covered by the original authorization has not expired.[18]

Box 2 describes standard and model notices developed by CMS for use in the unified appeal process.

Box 2: Standard and model notices for the unified appeal process

Coverage Decision Letter (CDL): AIPs must notify enrollees about adverse integrated organization determinations using the CMS-developed Coverage Decision Letter. This letter informs the enrollee of their right to appeal the plan's integrated organization determination decision and provides instructions on how to file an integrated appeal. Because this letter is issued as a standardized notice, D-SNPs (and states) may only edit content that is specifically identified as editable. AIPs must only use the 2025 version of the CDL.

Appeal Decision Letter: AIPs must send written notices to enrollees explaining plan decisions made about integrated appeals. Those notices must comply with the requirements at 42 CFR §422.633(f)(4). When a decision is not wholly favorable to the enrollee, the notice must explain the enrollee's further appeal rights under Medicare and Medicaid. CMS has provided a model notice that AIPs may use for this purpose. D-SNPs (and states) may edit the content of the CMS model notice as long as the final notice meets the federal requirements.

Letter About Your Right to Make a Fast Complaint: AIPs may use this model notice to meet the noticing requirements described at 42 CFR §§422.631 and 422.633 when the plan (1) extends the timeframe for deciding an integrated organization determination or integrated appeal or (2) denies a request for an expedited integrated organization determination or integrated appeal. Because this is a model notice, D-SNPs (and states) may edit it if the final notice meets the federal requirements for these notices.

These letters are available at: https://www.cms.gov/medicare/medicaid-coordination/about/dsnps. These notices are used with appeals filed using the unified appeal process. For appeals related to prescription drug coverage, AIPs (and other Medicare Advantage plans) use the Part D notices provided at https://www.cms.gov/medicare/appeals-grievances/prescription-drug/plan-sponsor-notices-documents.

Unified Grievance Process

Like the unified appeal process, the unified grievance process offers AIP enrollees a single pathway to file a grievance with their plan, regardless of whether the grievance involves a Medicare or Medicaid benefit. Enrollees may file a grievance orally or in writing with the plan at any time, or enrollees may file a grievance related to a Medicaid benefit with the state if the state has a process for accepting Medicaid grievances.[19] The plan must review and resolve standard grievances as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from receipt for a standard grievance and 24 hours for an expedited grievance.[20]

AIPs can extend the grievance response timeline by 14 calendar days if (1) the enrollee requests an extension or (2) the plan justifies the need for additional information and documents why the delay is in the enrollee's best interest.[21] Plans must make reasonable efforts to promptly notify the enrollee orally of the reasons for the delay, send the enrollee written notice of the reasons for the delay within two calendar days, and notify the enrollee that they can file a grievance if they disagree with the decision to delay.

State Roles in Unified Appeal and Grievance Processes

States play two key roles in the implementation of AIP unified appeal and grievance processes: (1) incorporating requirements related to those processes into the state's SMAC(s) with relevant D-SNP(s) and (2) overseeing D-SNP performance and compliance with any state-specific requirements.

SMAC requirements related to AIP unified appeal and grievance processes

SMACs with AIPs must require the AIPs to use the unified appeal and grievance processes described at 42 CFR §§422.629 – 422.634, as well as conforming Medicaid managed care rules at 42 CFR §§438.210, 438.400, and 438.402.[22] See Box 3 for sample SMAC language.

In addition to requiring AIPs to use the federally-required unified appeal and grievance processes, states can optionally incorporate other requirements into SMACs related to these processes, such as requiring AIPs to use state-specific language in certain notices and/or requiring them to use response timeframes or other standards that are more protective to enrollees than those in federal rules.

Box 3. Sample SMAC language requiring use of unified appeal and grievance processes

Consistent with state policy, the Contractor shall implement a grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§422.629 – 422.634, 438.210, 438.400, and 438.402. This includes:

- Appeal and grievance systems that meet the standards described in 42 CFR §422.629;
- An integrated grievance process that complies with 42 CFR §422.630;
- A process for making integrated organization determinations consistent with 42 CFR §422.631;
- Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR §422.632;
- A process for making integrated reconsiderations consistent with 42 CFR §422.633; and
- A process for effectuation of decisions consistent with 42 CFR §422.634.

Source: Integrated Care Resource Center. "Sample Language for State Medicaid Agency Contracts (SMACs) with Dual Eligible Special Needs Plans." January 2025. https://integratedcareresourcecenter.com/resources-by-topic/sample-SMAC-language.

Requiring AIPs to use shorter unified appeal and grievance timeframes or more protective noticing requirements than those in federal regulations

States can implement timeframe or noticing standards that are more protective of enrollees than those specified at 42 CFR §§422.629 – 422.634 if those state-specific standards are consistent with federal Medicaid rules.[23] For example, a state can require AIPs to respond to standard, integrated grievances within 20 calendar days of receipt of the grievance instead of responding within 30 calendar days, as required at 42 CFR §422.630(e)(1). This flexibility is particularly useful for aligning integrated appeal and grievance standards with existing state Medicaid managed care program standards.

If a state chooses to require more protective processes than those described in federal regulations, the state should clearly indicate those state-specific requirements in the AIP's SMAC. Any state-specific provisions should explicitly describe the state-specific standard and cite the federal requirement it is replacing. For example, if a state requires an AIP to use a 15-day timeframe for resolution of a standard, integrated appeal rather than the 30 calendar days allowed under the federal integrated appeal rules, the state could include the following language in the AIP's SMAC: *"The Contractor must resolve standard, integrated appeals within 15 calendar days of the date of receipt in lieu of the 30 calendar day timeline permitted under 42 CFR §422.631(f)(1)."*

States can also train AIP staff on unified appeal and grievance requirements, especially on any state-specific standards or expectations. See Box 4 for example training topics.

Box 4: Example unified appeal and grievance process training topics

The following are examples of topics that states could consider including in training sessions for AIPs on unified appeal and grievance processes:

1. D-SNP responsibilities and timelines in the unified appeal and grievance processes;
2. State-specific unified appeal and grievance requirements, such as shorter timeframes and/or requirements that are more protective to enrollees than federal requirements;
3. How D-SNPs should use appeal and grievance data to improve enrollee experiences and help maintain enrollment in the state's D-SNP program;
4. How to avoid common errors in enrollee notices, including the Coverage Decision Letter, the Letter About Your Right to Make a Fast Complaint, and the Appeal Decision Letter;
5. D-SNP responsibilities to oversee vendors that support unified appeal and grievance processes on behalf of the D-SNP; and
6. D-SNP responsibilities for appeals that progress to state fair hearings, additional state administrative levels, and/or state court.

Requiring AIPs to use state-specific language in unified appeal and grievance notices

AIPs must issue a variety of notices to enrollees related to unified appeals. See Box 5 for information about these notices.

Box 5. Unified appeal notices

AIPs must issue written notices to enrollees during each of the following stages or steps in the unified appeal process:

- **Integrated organization determination decisions:** When an AIP makes an adverse decision about an integrated organization determination, it must notify the enrollee using the CMS-developed Coverage Decision Letter. This letter informs the enrollee of their right to appeal the plan's integrated organization determination decision and provides instructions on how to file an integrated appeal.
- **Integrated organization determination dismissals:** If an AIP dismisses an integrated organization determination, it must send a written notice of the dismissal.[24] This notice must explain the reason for the dismissal, the right to request that the AIP vacate the dismissal, and the right to request reconsideration of the dismissal.
- **Integrated organization determination delays:** If an AIP extends the timeframe for making its integrated organization determination, it must notify the enrollee of the delay.[25] This notice must include the reason for the delay and explain the right to file an expedited grievance if the enrollee disagrees with the decision to delay.[26]
- **Expedited integrated organization determination request denials:** If an AIP denies a request for an expedited integrated organization determination, it must notify the enrollee orally and in writing.[27]
- **Appeal acknowledgments:** AIPs must send written acknowledgment to enrollees upon receiving appeal requests.[28]
- **Appeal dismissals:** If an AIP dismisses an appeal, it must send a written notice of the dismissal.[29] This notice must explain the reason for the dismissal, the right to request that the AIP vacate the dismissal, and the right to request review of the dismissal.
- **Appeal decision delays:** If an AIP extends the timeframe for deciding an appeal, it must notify the enrollee of the delay.[30] This notice must include the reason for the delay and explain the right to file an expedited grievance if the enrollee disagrees with the decision to delay.[31]
- **Expedited appeal request denials:** If an AIP denies a request for an expedited appeal, it must notify the enrollee orally and in writing. This notice must include the reason for the denial, the right to file a grievance if the enrollee disagrees with the decision not to expedite, and the right to resubmit a request for an expedited determination.[32]
- **Appeal decisions:** AIPs must notify enrollees of integrated appeal decisions in writing.[33] Those notices must comply with the requirements at 42 CFR §422.633(f)(4). CMS has provided a model notice that AIPs may use for this purpose, called the Appeal Decision Letter.[34]

While the Coverage Decision Letter described in Box 5 is a standardized template, states can modify bracketed text in the template to reflect state-specific Medicaid policies and provide that edited template to AIPs for use within that state. Additionally, because the Appeal Decision Letter and the Letter About Your Right to Make a Fast Complaint are models, states can either (1) modify the text and format of those models to reflect state-specific Medicaid policies and processes or (2) require D-SNPs to use different, state-developed templates. Similarly, states can require D-SNPs to use state-specific language or formats for notices involving dismissals, acknowledgments, and delays.

AIPs must also issue notices to enrollees in response to unified grievances.[35] Like appeal notices, states may also provide guidance or template language to AIPs for grievance notices to reflect state-specific Medicaid policies and processes. See Box 6 for more information on these notices.

Box 6. Unified grievance notices

AIPs must issue written notices to enrollees during each of the following stages or steps in the unified grievance process:

- **Grievance acknowledgments:** AIPs must send written acknowledgment to enrollees upon receiving integrated grievances.[36]
- **Grievance responses:** AIPs must respond to grievances.[37] Specifically, AIPs must (1) respond in writing to grievances submitted in writing, (2) respond either orally or in writing to grievances submitted orally, unless the enrollee requests a written response, and (3) respond in writing for all grievances related to quality of care, which must include a description of the enrollee's right to file a written complaint with the quality improvement organization (QIO) about Medicare-covered services.
- **Grievance response delays:** If an AIP extends the timeframe for resolving a grievance, it must notify the enrollee of the reasons for the delay.[38] This notice must explain the right to file an integrated grievance if the enrollee disagrees with the decision to delay.

All letters, including those developed or modified by plans and states, must meet the notice requirements detailed in the unified appeal and grievance regulations.[39] For example, appeal decision notices must use plain language, be available in a language and format that is accessible to enrollees, and explain the resolution of and basis for the appeal and the date that the plan completed the appeal. For appeals not resolved wholly in favor of the enrollee, the letter must also explain the next appeal level available through the Medicare and Medicaid programs, what steps the enrollee must take to pursue the next appeal level under each program, how the enrollee can obtain assistance in pursuing the next appeal level, and the right to request and receive Medicaid-covered benefits during the next appeal level.

Oversight of D-SNP performance and compliance with state requirements

CMS and states share responsibility for overseeing D-SNP compliance with unified appeal and grievance requirements. CMS oversees D-SNP compliance with federal unified appeal and grievance requirements, and states are responsible for overseeing D-SNP compliance with (1) state-specific unified appeal and grievance requirements and (2) use of state-specific language in appeal and grievance notices. For example, if a state requires a 15-day timeframe for resolution of a standard, integrated appeal rather than the 30 calendar days allowed under the federal integrated appeal rules, the state is responsible for monitoring D-SNP compliance with the state's stricter timeframe. D-SNPs are subject to a CMS Program Audit where adherence to federal appeal and grievance regulations are reviewed.

States can also use appeal and grievance data to monitor D-SNP performance—specifically, to detect D-SNP quality, access, and enrollee experience performance improvement opportunities. For example, high rates of overturned appeals in a particular service area can indicate access challenges, and grievance trends can reveal issues with quality of care, enrollee experience, access to care, or care transitions. ICRC's D-SNP quality improvement resources describe how states can use data to identify

performance improvement opportunities and intervene to improve D-SNP performance, and states can incorporate integrated appeal and grievance data into these processes.[40]

Because AIPs must maintain integrated appeal and grievance records in a manner accessible to states,[41] they are well positioned to submit data that states can use to monitor and improve D-SNP performance. For example, these data could include:

- The number of integrated appeals received, the outcomes of those appeals, the services and/or issues involved, and the number of appeals in which the AIP's decision was ultimately overturned during a later stage of the appeal process.
- The number of integrated grievances received, grievance outcomes, the types of services involved (for example, behavioral health, transportation, dental services, etc.), and the types of issues involved (for example, access to care, quality of care, accessibility of plan materials, etc.).

Box 7 contains sample language that states can use to require AIPs to submit integrated appeal and grievance data to the state.

Box 7: Sample SMAC language requiring AIPs to submit appeal and grievance data to the state

The Contractor shall submit integrated appeal and grievance data to the State in accordance with *[insert details about the submission schedule and method]*. The Contractor's integrated appeal and grievance reports shall include the following information: *[Specify required data, such as integrated grievances and appeal requests received that the state can use to monitor and improve D-SNP performance]*. The integrated appeal and grievance reports shall adhere to the data specification and format requirements included in *[specify reference to appendix, manual, or other document that specifies data requirements]*.

Source: Integrated Care Resource Center. "Sample Language for State Medicaid Agency Contracts (SMACs) with Dual Eligible Special Needs Plans." January 2025. https://integratedcareresourcecenter.com/resources-by-topic/sample-SMAC-language.

Conclusion

AIPs must use the unified appeal and grievance processes detailed at 42 CFR §§422.629 – 422.634 for all Medicare and Medicaid benefits (other than Medicare Part D benefits). States that contract with AIPs should use SMACs to require AIPs to use the unified appeal and grievance processes. States can also impose additional requirements that go beyond these minimum standards, such as requiring AIPs to use shorter appeal and grievance timeframes and/or take other steps that are more protective for enrollees than those included in federal rules, requiring AIPs to use state-specific language in certain unified appeal and grievance letters, or participating in state-specific training. While CMS oversees AIP compliance with federal requirements, states are responsible for overseeing plan compliance with state-specific unified appeal and grievance requirements. States can also collect and use appeal and grievance data to monitor and improve D-SNP performance.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] More information on AIPs is available in ICRC's tip sheet on the different types of D-SNPs: https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

[2] The unified appeal process does not modify any post-plan level appeal processes, such as Medicare Independent Review Entity decisions or Medicaid state fair hearings.

[3] ICRC's glossary of key terms related to dual eligibility and integrated care programs for dually eligible individuals is available at https://www.integratedcareresourcecenter.com/resource/glossary-terms-related-integrated-care-dually-eligible-individuals.

[4] ICRC's tip sheet on the different types of D-SNPs is available at https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

[5] ICRC's resources on exclusively aligned enrollment are available at https://www.integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment.

[6] Medicare Part D appeal and grievances notices are available at https://www.cms.gov/medicare/appeals-grievances/prescription-drug/plan-sponsor-notices-documents.

[7] In rare cases when a prescription drug is excluded from coverage under Part D but covered by Medicaid, AIPs should issue Medicaid coverage notices and follow Medicaid appeal processes.

[8] ICRC's flowcharts that compare the separate and unified Medicare and Medicaid appeal and grievance processes are available at https://www.integratedcareresourcecenter.com/resource/appeals-and-grievances-comparisons-existing-and-new-integrated-processes-individuals.

[9] An enrollee, authorized representative, or a provider may request an integrated organization determination for services or benefits orally or in writing. Requests for payment must be in writing unless the AIP accepts verbal payment requests. For more information, see 42 CFR §422.631(b) and 42 CFR §422.629(l).

[10] 42 CFR §422.631(d)(2)(i)(A).

[11] 42 CFR §422.631(d)(2)(i)(B).

[12] 42 CFR §422.631(d)(2)(i)(B).

[13] AIPs may extend the timeframe for standard and expedited integrated organization determinations by up to 14 calendar days in certain circumstances. For details, see 42 CFR §422.631(d)(2)(ii).

[14] The date of receipt of the adverse organization determination is presumed to be five calendar days after the date of the integrated organization determination notice. This means that enrollees effectively have 65 days to file an appeal after the AIP issues the notice. AIPs may extend the timeframe for filing an appeal in certain circumstances. For more information, see 42 CFR §422.633(d).

[15] 42 CFR §422.633(f).

[16] 42 CFR §422.633(f)(3).

[17] More information on integrated appeal resolution and notification requirements is available at 42 CFR §422.633(f)(4).

[18] More information on continuation of benefits while a unified appeal is pending is available at 42 CFR §422.632.

[19] 42 CFR §422.630(c).

[20] Regulations at 42 CFR §422.630(d) describe which grievances qualify as expedited grievances. Specifically, an AIP must respond to an enrollee's grievance within 24 hours if the grievance involves the plan's (1) decision to invoke an extension relating to an integrated organization determination or integrated appeal, or (2) refusal to grant an enrollee's request for an expedited integrated organization determination or expedited appeal.

[21] 42 CFR §422.630(e)(2)

[22] The minimum elements that must be included in SMACs with different types of D-SNPs are described at 42 CFR §422.107(c) – (d). SMACs with AIPs must require the AIPs to use the integrated appeal and grievance process, per the language at 42 CFR §422.107(c)(9). More information on SMACs and the minimum elements that they must contain is available at: https://integratedcareresourcecenter.com/resources-by-topic/sample-SMAC-language.

[23] 42 CFR §422.629(c)

[24] 42 CFR §422.631(f).

[25] 42 CFR §422.631(d)(2)(iii)(A).

[26] AIPs may send the Letter about Your Right to Make a Fast Complaint to meet the requirements of 42 CFR §§422.631 and 422.633 when the plan makes a decision to (1) extend the timeframe for deciding an integrated organization determination or integrated appeal, or (2) deny a request for an expedited integrated organization determination or integrated appeal.

[27] 42 CFR §422.631(d)(2)(iv)(B)(2). AIPs may send the Letter about Your Right to Make a Fast Complaint to meet the requirements of 42 CFR §§422.631 and 422.633 when the plan makes a decision to 1) extend the timeframe for deciding an integrated organization determination or integrated appeal, or 2) deny a request for an expedited integrated organization determination or integrated appeal.

[28] 42 CFR §422.629(g).

[29] 42 CFR §422.633(i).

[30] 42 CFR §422.633(f)(3)(ii).

[31] AIPs may send the Letter about Your Right to Make a Fast Complaint to meet the requirements of 42 CFR §§422.631 and 422.633 when the plan makes a decision to 1) extend the timeframe for deciding an integrated organization determination or integrated appeal, or 2) deny a request for an expedited integrated organization determination or integrated appeal.

[32] 42 CFR §422.633(e)(4). AIPs may send the Letter about Your Right to Make a Fast Complaint to meet the requirements of 42 CFR §§422.631 and 422.633 when the plan makes a decision to 1) extend the timeframe for deciding an integrated organization determination or integrated appeal, or 2) deny a request for an expedited integrated organization determination or integrated appeal.

[33] 42 CFR §422.633(f)(4).

[34] The Appeal Decision Letter is available at https://www.cms.gov/medicare/medicaid-coordination/about/dsnps.

[35] 42 CFR §422.630(e).

[36] 42 CFR §422.629(g).

[37] 42 CFR §422.630(e)(1).

[38] 42 CFR §422.630(e)(2).

[39] More information on integrated organization determination, appeal, and grievance resolution and notification requirements is available at 42 CFR §§422.629(g), 422.630(e), 422.631(d), 422.631(f), and 422.633(e) – (f), and 422.633(i).

[40] See ICRC's quality improvement tip sheets and webinars at: https://www.integratedcareresourcecenter.com/resource-category/quality-and-performance-measurement.

[41] More information on recordkeeping requirements is available at 42 CFR §422.629(h).

Appendix A: Unified Appeal and Grievance Requirements for Prescription Drugs Covered by Medicare Part B

Applicable integrated plans (AIPs) must follow the federal requirements at 42 CFR §§422.629 – 422.634 when establishing unified appeal and grievance processes for services covered under Medicare Part A, Medicare Part B, and Medicaid. For appeals and grievances related to prescription drugs covered by Medicare Part D, these plans must follow the requirements provided at 42 CFR §423 Subpart M. For prescription drugs covered by Medicare Part B, AIPs must follow the general process requirements at 42 CFR §§422.629 – 422.634, but the timeframes for making integrated organization determinations, resolving integrated appeals (reconsiderations), and reinstating services regarding those Part B drugs are described at 42 CFR §§422.568(b)(3), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), and 422.590(e)(2). In some cases, those timeframe requirements differ from the requirements described at 42 CFR §§422.629 – 422.634.

Table A.1 summarizes the timeframe requirements for integrated organization determinations and appeals related to prescription drugs covered by Part B and highlights the ways in which those timeframe requirements align with (or differ from) the timeframes provided at 42 CFR §§422.629 – 422.634 for integrated appeals related to other services.

Table A.1. Federal unified appeal and grievance requirements for Part B prescription drug coverage

	Requirements for Part B-covered drugs	Requirements for other benefits covered by Medicare Part A, Medicare Part B, or Medicaid
Criteria for extensions of standard and expedited integrated organization determinations See 42 CFR §§422.568(b)(3), 422.572(a)(2), and 422.631(d)(2)(ii).	The AIP may not extend the standard or expedited processing timeframes for integrated organization determination requests for Part B drugs.	The AIP may extend the timeframe for making an integrated organization determination by up to 14 calendar days if: • The enrollee or provider requests the extension; or • The AIP can show that the extension is in the enrollee's interest, there is a need for additional information, and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.
Timeframes for notifying enrollees of standard integrated organization determinations See 42 CFR §§422.568(b)(3) and 422.631(d)(2)(i)(B).	The AIP must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of the organization determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request for the determination. The AIP cannot extend this timeframe.	The AIP must send a notice of its integrated organization determination as expeditiously as the enrollee's health condition requires but no later than either of the following: • For a service or item not subject to the prior authorization rules at 42 CFR §422.122, 14 calendar days after receiving the request for the determination; • For a service or item subject to the prior authorization rules at 42 CFR §422.122, 7 calendar days after receiving the request for the determination. The AIP can extend this timeframe.

	Requirements for Part B-covered drugs	Requirements for other benefits covered by Medicare Part A, Medicare Part B, or Medicaid
Timeframes for notifying enrollees of expedited integrated organization determinations See 42 CFR §§422.572(a)(2) and 422.631(d)(2)(iv)(A).	The AIP must make its determination and notify the enrollee (and the physician or prescriber involved, as appropriate) of its decision as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request. The AIP cannot extend this timeframe.	The AIP must provide notice of its expedited integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. The AIP can extend this timeframe.
Timeframes for notifying enrollees of integrated organization determinations after an AIP denies a request for an expedited determination See 42 CFR §§422.568(b)(3), 422.570(d)(2), and 422.631(d)(2)(iv)(B)(2).	If the AIP denies a request for an expedited integrated organization determination, it must give the enrollee prompt oral notice of the denial and deliver a letter within 3 calendar days that explains that the AIP will process the request using the 72-hour timeframe for standard Part B drug determinations.	If the AIP denies a request for an expedited integrated organization determination, it must give the enrollee prompt oral notice of the denial and deliver a written letter within 3 calendar days that explains that the AIP will process the request as expeditiously as the enrollee's health condition requires using the timeframe for standard integrated organization determinations. For a service or item *not* subject to prior authorization rules at 42 CFR §422.122, the standard timeframe for making the determination and notifying the enrollee is 14 calendar days. For a service or item that *is* subject to prior authorization rules at 42 CFR §422.122, the standard timeframe for making the determination and notifying the enrollee is 7 calendar days.
Timeframes for resolving standard integrated appeals See 42 CFR §§422.590(c), 422.633(f)(1), and 422.634(b)(1)(ii).	For standard integrated appeal decisions that are completely favorable to the enrollee, the AIP must issue the determination as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it received the request for a standard appeal. The AIP cannot extend this timeframe. For standard integrated appeal decisions that are not wholly in favor of the enrollee, the AIP must prepare a written explanation and send the case file to the independent review entity no later than 7 calendar days from the date it receives the request for a standard appeal. The AIP must make reasonable and diligent efforts to assist in gathering and forwarding the information to the independent entity.	The AIP must make standard integrated appeal determinations as expeditiously as the enrollee's health condition requires but no later than 30 calendar days from the date of receipt of the request for the integrated appeal. The AIP can extend this timeframe. For standard integrated appeal decisions that are not wholly in favor of the enrollee, the AIP must prepare a written explanation and send the case file to the independent review entity no later than 30 calendar days from the date it receives the request for a standard appeal. The AIP must make reasonable and diligent efforts to assist in gathering and forwarding the information to the independent entity.

	Requirements for Part B-covered drugs	Requirements for other benefits covered by Medicare Part A, Medicare Part B, or Medicaid
Timeframes for resolving expedited integrated appeals See 42 CFR §§422.590(e)(2), 422.633(f)(2), and 422.634(b)(1)(iii).	The AIP that approves an expedited integrated appeal must give the enrollee (and the physician or other prescriber involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request. The AIP cannot extend this timeframe. For expedited integrated appeal decisions that are not wholly in favor of the enrollee, the AIP must prepare a written explanation and send the case file to the independent review entity as expeditiously as the enrollee's health condition requires, but not later than 24 hours of its affirmation. The AIP must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent review entity.	The AIP must resolve expedited integrated appeals as expeditiously as the enrollee's health condition requires but no later than 72 hours after receipt of the integrated appeal. The AIP can extend this timeframe. For expedited integrated appeal decisions that are not wholly in favor of the enrollee, the AIP must prepare a written explanation and send the case file to the independent review entity as expeditiously as the enrollee's health condition requires, but not later than 24 hours of its affirmation. The AIP must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent review entity.
Timeframes for resolving integrated appeals after an AIP denies a request for an expedited appeal See 42 CFR §§422.584(d)(1) and 422.633(e)(4).	If an AIP denies an enrollee's request for an expedited integrated appeal, it must automatically transfer the request to the standard timeframe and make its determination as expeditiously as the enrollee's health condition requires, but not later than 7 calendar days after receiving the expedited appeal request.	If the AIP denies an enrollee's request for an expedited integrated appeal, it must automatically transfer the request to the standard timeframe and make its determination as expeditiously as the enrollee's health condition requires, but not later than 30 calendar days after receiving the expedited appeal request.
Timeframes for restoring services after an AIP reverses its decision during an integrated appeal See 42 CFR §422.634(d).	If an AIP reverses its decision to deny, limit, or delay services that were not furnished while an appeal was pending, it must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than the earlier of: • 72 hours from the date it reversed its decision; or • 7 calendar days after the date the AIP received the request for the integrated appeal.	If an AIP reverses its decision to deny, limit, or delay services that were not furnished while an appeal was pending, it must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than the earlier of: • 72 hours from the date it reversed its decision; or • 30 calendar days after the date the AIP received the request for the integrated appeal (or no later than upon expiration of an extension).