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Integrated Appeal and Grievance Processes for Integrated D-SNPs with "Exclusively Aligned Enrollment"

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Individuals dually eligible for Medicare and Medicaid must navigate separate, and in some cases conflicting, appeal and grievance processes within Medicare and Medicaid. Integrated plans that cover both Medicare and Medicaid benefits are designed to help alleviate this challenge, but historically, even enrollees in integrated plans have had to navigate separate processes when filing appeals or grievances. To address this issue, the Centers for Medicare & Medicaid Services (CMS) began requiring integrated appeal and grievance processes for dually eligible individuals enrolled in certain Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) in 2021. On April 16, 2019, CMS released a final rule[1] that implemented provisions of the 2018 Bipartisan Budget Act (BBA) requiring greater D-SNP integration, including integrated plan-level appeal and grievance processes for certain "applicable integrated plans." This fact sheet is intended to help states with applicable integrated plans understand these integrated appeal and grievance processes, the types of D-SNPs that are required to use them, and steps that states can take to help ensure effective implementation.

In Brief: Key Points in this Tool

Summary of integrated processes. In standard Medicare and Medicaid appeal and grievance processes, dually eligible individuals must follow separate Medicare and Medicaid appeal and grievance pathways that differ in key respects. The integrated processes offer integrated plan-level appeal and grievance pathways for all Medicare and Medicaid benefits, resolve misalignments between Medicare and Medicaid plan-level processes, and result in simpler, more straightforward experiences for enrollees, states, and plans. In addition, states may implement requirements through their State Medicaid Agency Contracts (SMAC) that are more protective for enrollees than those described in federal regulation. The April 2019 final rule did not modify post-plan level Medicare and Medicaid appeal processes.

Applicable integrated plans. The integrated appeal and grievance processes apply only to D-SNPs that qualify as "applicable integrated plans." In 2021, the only D-SNPs that qualified as "applicable integrated plans" were Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) with exclusively aligned enrollment. Starting in 2023, some "coordination only" D-SNPs will begin qualifying as applicable integrated plans if they operate with exclusively aligned enrollment and cover at least certain Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan. Additionally, starting in 2025, all FIDE SNPs must have exclusively aligned enrollment; therefore, all FIDE SNPs will qualify as applicable integrated plans starting in 2025. CMS designates applicable integrated plans at the plan benefit package level.

Exclusively aligned enrollment. Exclusively aligned enrollment occurs when the state contract limits enrollment in the D-SNP to full-benefit dually eligible individuals who receive their Medicaid benefits from the D-SNP or from an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP. For more information about exclusively aligned enrollment, see ICRC's May 2022 webinar.[2]

Key dates and relevant SMAC language. Applicable integrated plans must have integrated appeal and grievances processes in effect starting January 1 of the first calendar year of designation as an applicable integrated plan. The SMACs submitted in July of the preceding year by D-SNPs that expect to be applicable integrated plans must include a provision requiring use of integrated appeal and grievance processes. See Box 3 for sample contract language.

Applicable Integrated Plans

The integrated appeal and grievance processes initiated in 2021 apply to "applicable integrated plans," a term that is defined at 42 CFR 422.561 and was amended by 87 FR 27780. In 2021, the only D-SNPs that qualified as "applicable integrated plans" were Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) with exclusively aligned enrollment. As a result of a final rule issued in May 2022,[3] starting in 2023, some "coordination only" D-SNPs[4] will begin qualifying as applicable integrated plans if they operate with exclusively aligned enrollment and cover at least certain Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan. Specifically, the coordination only D-SNP or its affiliated Medicaid managed care plan must cover Medicaid primary and acute care benefits, including Medicare cost sharing, for D-SNP enrollees, as well as at least one of the following types of Medicaid services: (1) Medicaid home health services; (2) Medicaid medical supplies, equipment, and appliances; or (3) Medicaid nursing facility services. Additionally, starting in 2025, all FIDE SNPs must have exclusively aligned enrollment; therefore, all FIDE SNPs will qualify as applicable integrated plans starting in 2025. CMS designates applicable integrated plans at the plan benefit package level.

D-SNPs that do not qualify as applicable integrated plans will continue to use existing Medicare appeal and grievance processes for Medicare benefits. The existing processes are illustrated in an ICRC resource[6] and are required under 42 CFR Part 438 Subpart F and 42 CFR Part 422 Subparts M and N.

Box 1. Requirements for all D-SNPs to Assist Enrollees

The April 16, 2019 final rule requires all D-SNPs to coordinate the delivery of Medicaid benefits. At a minimum, D-SNPs must offer their enrollees assistance with Medicaid benefits, including requests for services and navigating Medicaid appeals and grievances, regardless of whether the services are covered through Medicaid fee-for-service or a Medicaid managed care plan. See 42 CFR 422.562(a)(5)(i) (p. 15834 of the final rule) for examples of such assistance.[5]

Integrated Appeal and Grievance Processes

Summary of the Integrated Appeal Process

The existing Medicare and Medicaid appeal processes require dually eligible individuals to navigate separate appeal pathways, depending on whether the benefit in question is covered by Medicare, Medicaid, or both. For example, even if an individual is enrolled in Medicare and Medicaid plans operated by the same parent company, these processes differ in certain respects, such as the timeframes in which a plan must make a decision about an enrollee's grievance.

The integrated appeal process resolves these misalignments by creating a single appeal pathway at the plan level for all Medicare (other than Medicare Part D) and Medicaid benefits for enrollees in applicable integrated plans.[8] The process begins when an individual requests coverage for a particular service or benefit from their plan.[9] Regardless of whether the service or benefit would typically be covered by Medicare, Medicaid, or both, the plan must make a decision about the request as expeditiously as the enrollee's health condition requires, but no longer than 14 days for a standard request[10] and within 72 hours for an expedited request.[11] If the plan denies

Box 2. Appeal and Grievance Process Flowcharts

ICRC provides a detailed comparison of the integrated appeal and grievance processes with the existing Medicare and Medicaid processes in the resource "*Appeals and Grievances: Comparisons of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans*."[7]

the request, or if it reduces, suspends, or terminates a previously authorized benefit, the enrollee may file an appeal with the plan.[12] The plan has 30 days to make a decision about the appeal if the enrollee uses the standard appeal process and 72 hours to make a decision if the enrollee uses the expedited appeal process. As in the Medicaid appeal process, the integrated appeal process allows individuals to continue their benefits subject to an appeal if they meet certain requirements.[13] This continuation of benefits is available for all ongoing services, including those covered by Medicare. The integrated appeal process does not modify any post-plan appeal processes, including Medicare Independent Review Entity decisions and Medicaid state fair hearings.

Summary of the Integrated Grievance Process

Like the integrated appeal process, the integrated grievance process offers individuals a single pathway to file a grievance with their plan, regardless of whether the grievance involves the delivery of a Medicare or a Medicaid benefit. An individual may file a grievance verbally or in writing at any time with their plan. The plan must respond to a standard grievance within 30 days and to an expedited grievance within 24 hours.

Potential Benefits of the Integrated Appeal and Grievance Processes

The integrated processes may offer states, enrollees, and applicable integrated plans various benefits, including:

- **State flexibilities.** States may implement timeframe or notice requirements that are more protective for enrollees than those included in the integrated process regulations, as long as the state-specific requirements are consistent with federal Medicaid regulations.

- **Streamlined experiences for dually eligible individuals.** Because the integrated appeal and grievance processes offer single pathways for all Medicare and Medicaid benefits, dually eligible individuals will no longer need to determine whether to use the Medicare pathway, the Medicaid pathway, or both. Additionally, the integrated processes strengthen enrollee protections by adopting either the Medicare or Medicaid standard that is more protective of enrollees. For example, as under Medicaid managed care rules, the integrated processes allow an enrollee to file a grievance at any time and to continue receiving denied, reduced, or suspended benefits during an appeal.

- **Administrative efficiencies for plans.** Applicable integrated plans are likely to benefit from administrative efficiencies resulting from the integrated appeal and grievance pathways because they will no longer have to simultaneously implement two separate processes to comply with differing Medicare and Medicaid appeal and grievance requirements. For instance, if an item or service is fully covered under the Medicaid benefits offered by the plan, the plan will never have to send a notice denying Medicare coverage.

State Roles in Implementing Integrated Appeal and Grievance Processes

States that contract with applicable integrated plans should consider taking the following steps to ensure that those plans effectively implement the new integrated appeal and grievance processes in 2021:

- **Contract updates.** All D-SNPs must have contracts with state Medicaid agencies, referred to as the SMAC or "MIPPA contract." States will need to update their SMACs to require applicable integrated plans to use the integrated appeal and grievance processes starting January 1, 2021. Specifically, SMACs should require plans to use the integrated appeal and grievance processes described at 42

CFR 422.629 through 422.634, as well as conforming Medicaid managed care rules at 42 CFR 438.210, 438.400, and 438.402. Box 3 provides an example of the type of language that states can add to their SMACs to require compliance with 42 CFR 422.629 through 422.634. States can also review ICRC's SMAC sample language resource for additional contract language suggestions.[14]

- **Flexible appeal and grievance standards.** States may implement timeframe or notice standards that are more protective of enrollees than those specified for the integrated appeal and grievance processes under 42 CFR 422.629 – 422.634, as long as those state-specific standards are consistent with federal Medicaid rules. These include, for example, requiring plans to make a decision on an appeal within shorter timeframes than those described in federal regulations. States that use more protective standards must specify their requirements in their SMACs. This flexibility is particularly useful for aligning integrated appeal and grievance standards with existing state Medicaid standards.

- **Updates to enrollee notices.** The integrated appeal process includes use of a new integrated benefit denial notice as required under 42 CFR 422.631(d).[15] Applicable integrated plans will use this letter beginning in 2021 in place of the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS-10003). All other MA plans will continue to use the NDMCP. CMS has also developed other model notices that plans may use in other parts of the integrated appeals process.[16] States should ensure that D-SNPs and affiliated Medicaid MCOs use the appropriate notices with correct state-specific information.

- **Key dates.** The integrated appeal and grievance requirements went into effect January 1, 2021, and new types of D-SNPs will begin qualifying as applicable integrated plans January 1, 2023. States with D-SNPs that may qualify as applicable integrated plans should discuss the requirements for integrated appeal and grievances processes with their D-SNPs and make sure that appropriate contract provisions are included in the states' SMACs with those D-SNPs. D-SNPs must submit to CMS executed SMACs for each state in which they seek to operate by early July of the preceding calendar year.

Box 3. Sample SMAC Language Requiring Integrated Appeal and Grievance Processes

The following sample SMAC language for integrated appeal and grievance processes is designed for states that contract with applicable integrated plans:

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

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

States can review ICRC's SMAC sample language resource for additional contract suggestions.[17]

Additional Resources

States may contact MMCO for technical assistance at: MMCO_DSNPOperations@cms.hhs.gov.

For more information related to the integrated appeal and grievance processes, see:

- **Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)** (MMCO, January 2020). This guidance clarifies: (1) distinctions between HIDE SNPs and FIDE SNPs; (2) permissibility of carve-outs of behavioral health services and LTSS for HIDE SNPs and FIDE SNPs; (3) alignment of D-SNP and companion Medicaid plan service areas; and (4) compliance with integration requirements for D-SNPs that only enroll partial-benefit dually eligible individuals. Available at: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

- **Appeals and Grievances: Comparisons of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans** (ICRC, January 2020). The flow charts in this resource 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. Available at: https://www.integratedcareresourcecenter.com/resource/appeals-and-grievances-comparisons-existing-and-new-integrated-processes-individuals

- **Final Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance** (CMS, December 2020). This addendum applies only to applicable integrated plans as defined in 42 CFR § 422.561 and became effective on January 1, 2021. It supplements the Part C & D Guidance for applicable integrated plans unifying grievances and appeals procedures, notes in corresponding sections where requirements for applicable integrated plans differ from requirements from other Medicare Advantage plans due to differences in governing regulations, and clarifies certain requirements and processes for applicable integrated plans. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

- **CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)** (MMCO, October 2019). This memorandum summarizes the new D-SNP integration and appeal and grievance requirements. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf
  Note that in response to Coronavirus Disease 2019 (COVID-19), MMCO revised the timeline described in the October memorandum in a memo released April 13, 2020. Available at: https://www.cms.gov/files/document/dsnpscovid19cy2021statemedicaidagencycontractrequirements.pdf

- **Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021** (CMS, April 2019). This final rule revised Medicare Advantage regulations, including introducing the new integrated

appeal and grievance processes for applicable integrated plans, pursuant to the 2018 BBA. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

- **Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs** (CMS, May 2022). This final rule revised the definition of applicable integrated plan. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

- **Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans** (ICRC, Updated May 2020). This technical assistance tool provides sample contract language that states can use in their D-SNP SMACs. Available at: https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans

- **Working with Medicare Webinar – State Contracting with D-SNPs: Introduction to D-SNPs and D-SNP Contracting Basics** (ICRC, December 2020)**.** This webinar is part one of a two-part series that provides an overview of state strategies for contracting with D-SNPs to improve care coordination and Medicare-Medicaid alignment for dually eligible enrollees. It includes a brief summary of the integrated appeal and grievance requirements for applicable integrated plans. Available at https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-introduction-d-snps-and-d-snp-contracting

- **Exclusively Aligned Enrollment 101: Considerations for States Interested in Leveraging D-SNPs to Integrate Medicare and Medicaid Benefits** (ICRC, May 2022). This webinar provides an overview of how exclusively aligned enrollment promotes integration of Medicare and Medicaid benefits within Dual Eligible Special Needs Plans (D-SNPs) and key considerations for states in designing and implementing exclusively aligned enrollment. Available at: https://www.integratedcareresourcecenter.com/webinar/exclusively-aligned-enrollment-101-considerations-states-interested-leveraging-d-snps

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 dually eligible individuals. 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**.

[1] CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." April 16, 2019. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[2] Integrated Care Resource Center (ICRC). "Exclusively Aligned Enrollment 101: Considerations for States Interested in Leveraging D-SNPs to Integrate Medicare and Medicaid Benefits." Study Hall Call, May 2022. Available at:

https://www.integratedcareresourcecenter.com/webinar/exclusively-aligned-enrollment-101-considerations-states-interested-leveraging-d-snps

[3] CMS. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." May 9, 2022. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

[4] "Coordination only" D-SNPs are D-SNPs that do not qualify for FIDE SNP or HIDE SNP designation.

[5] CMS, 2019.

[6] ICRC. "Appeals and Grievances: Comparisons of Existing and New Integrated Processes for Individuals Enrolled in Applicable Integrated Plans." January 2020. Available at: https://www.integratedcareresourcecenter.com/resource/appeals-and-grievances-comparisons-existing-and-new-integrated-processes-individuals

[7] Ibid.

[8] Medicare Part D prescription drug benefits are not included in the integrated grievance and appeal processes.

[9] Enrollees, providers, and approved representatives may submit pre-service requests verbally or in writing. Requests for payment must be in writing unless the plan accepts verbal requests. For more information, see 42 CFR 422.631(b). Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=552a11f01d59e79e3fef86cea08a97f7&mc=true&node=20190416y1.31.

[10] Medicare Part B drug appeals are subject to shorter timeframes as specified in the regulations. For more information see Appendix 1 of CMS' "Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance." Available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

[11] The plan must make a decision on a request when it determines (based on a request from the enrollee or on its own) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard request could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. For more information, see 42 CFR 422.631(c)(3). Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=552a11f01d59e79e3fef86cea08a97f7&mc=true&node=20190416y1.31

[12] Enrollees, providers, and approved representatives may request an appeal verbally or in writing within 60 days of the plan's adverse organization determination notice. For more information, see 42 CFR 422.633(d). Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=552a11f01d59e79e3fef86cea08a97f7&mc=true&node=20190416y1.31

[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. For more information, see 42 CFR 422.632. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=552a11f01d59e79e3fef86cea08a97f7&mc=true&node=20190416y1.31

[14] ICRC. "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans." May 2020. Available at: https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans

[15] The integrated denial notice for use by applicable integrated plans, known as the "Coverage Decision Letter," is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

[16] The models "Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter" are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

[17] ICRC. "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans." May 2020. Available at: https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans