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UNIFIED APPEALS AND GRIEVANCE PROCESS FOR MEDICAID ADVANTAGE PLUS (MAP) PLANS

BMLTC

OCTOBER 2025

AGENDA

- Background
- Definitions
- Differences between MAP Demo and Unified Appeals and Grievances
- Aid Continuing
- Appeals & Grievances (A&G) Timeframes

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MAP APPEALS & GRIEVANCES DEMONSTRATION BACKGROUND

Background:

- As of 1/1/2020, NY MAP plans began participating in MAP Integrated A&G Demonstration.
- Purpose of the demo was to create an integrated appeals and grievances process for the dual eligible population where services may be covered by both Medicare and Medicaid.
- Level 2 appeals for Medicare/Medicaid services were auto-forwarded to Office of Administrative Hearings (OAH).
- Plans required to use specific member notices as well as provide quarterly report on initial decisions, appeals and outcomes.

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MAP APPEALS & GRIEVANCES DEMONSTRATION BACKGROUND

MAP A&G Demo Process currently includes the following appeal levels:

- Level 1: Initial appeal to the MAP plan
- Level 2: Appeal to the Office of Administrative Hearings (OAH), at OTDA
- Level 3: Appeal to Medicare Appeals Council
- Level 4: Appeal to Federal District Court

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UNIFIED APPEALS AND GRIEVANCE BACKGROUND

- In Medicare Advantage regulations at 42 C.F.R. Part 422, the Centers for Medicare and Medicaid (CMS) categorized FIDE D-SNPs into a subset of plans called Applicable Integrated Plans (AIP), defined at 42 C.F.R. §422.560–562, 422.566, 422.629–634, 438.210, 438.400, and 438.402.
- In 2021, Medicare Advantage regulations required D-SNPs that met the definition of AIP to operate a unified appeals and grievance (A&G) process at the plan level to further integrate Medicare and Medicaid coverage for dual eligibles.
- The MAP plans were exempt from the unified A&G requirement due to operating under the integrated A&G demonstration with CMS.
- Due to the phase out of the demonstration, beginning January 1st, 2026, MAP plans will be required to operate the unified A&G process.

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APPEALS & GRIEVANCES DEFINITIONS

- ***Applicable Integrated Plan (AIP)*:** an integrated D-SNP that has exclusively aligned enrollment.
- ***Dually Eligible (Dual):*** a Medicaid recipient who is also eligible for Medicare.
- ***Dual Eligible Special Needs Plan (D-SNP):*** a specialized type of Medicare Advantage plan that enrolls individuals who have both Medicare and Medicaid coverage.
- ***Exclusively Aligned Enrollment:*** enrollment in the D-SNP is limited by the State to only those full benefit dual eligibles who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP.

APPEALS & GRIEVANCES DEFINITIONS

- ***Integrated Organization Determination***: an initial decision regarding payment or services to which the enrollee believes they are entitled.
- ***Independent Review Entity (IRE)*:** an independent entity that reviews plan appeal decisions. Currently, MAXIMUS Federal Services is the IRE contracted through the Centers for Medicare & Medicaid Services (CMS).
- ***Integrated Reconsideration***: the review of adverse integrated organization determination, synonymous with a plan appeal or Level 1 appeal.

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APPEALS & GRIEVANCES DEFINITIONS

- ***Unified Appeals Process:*** a procedure for certain FIDE and/or HIDE D-SNPs determined to be applicable integrated plans to be used for processing grievances and plan level appeals.
- ***Integrated Complaint***: an expression of dissatisfaction with any aspect of the plan or provider's operations, activities, or behavior, regardless of whether remedial action is requested.
  - NOTE: CMS refers to the above as an ***integrated grievance***, however for the purposes of this training, a grievance shall mean the review of administrative plan determinations pursuant to PHL 4408-a, excluding complaints.

DIFFERENCES BETWEEN THE MAP DEMO AND UNIFIED A&G PROCESS

- Service Authorization Requests (Integrated Organization Determinations) and Level 1 Appeals (Integrated Reconsiderations) remain integrated for services covered by both the Medicare and Medicaid programs.
- Level 2 Appeal and Complaint processes will change with the new unified A&G process.
- At the Level 2 Appeal, when services are covered under both Medicare and Medicaid, and the Level 1 Appeal (Integrated Reconsideration) is adverse, the plan's decision is auto-forwarded to the IRE **and** the enrollee may also choose to file a Medicaid Fair Hearing, and, in some instances, an External Appeal.
- Note: Appeals for services requested before the end of the Demonstration, will continue to follow the current four level integrated appeals process. Latest date for the member to submit an initial appeal for 2025 benefits and services is ***April 19, 2026*** (65 days to file appeal, 30 days for plan to adjudicate and 14 days extension.

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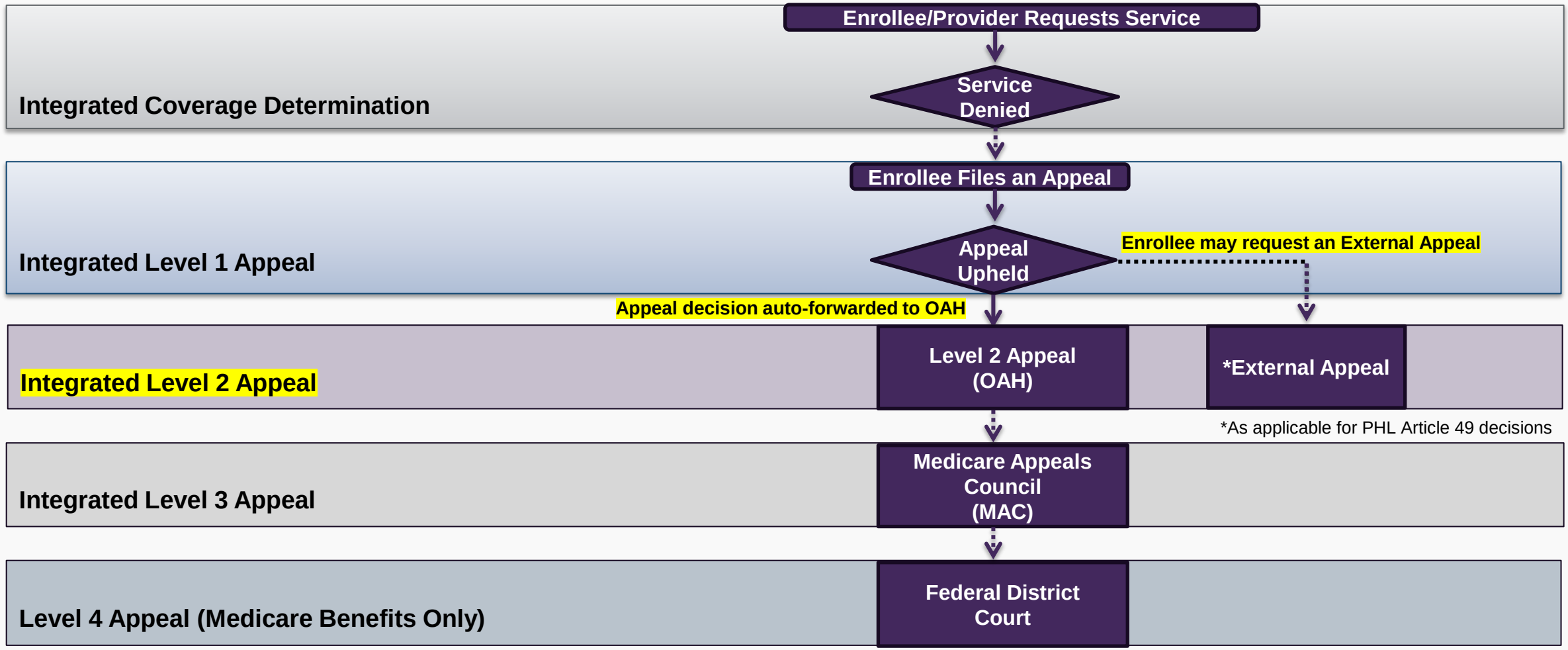
MAP DEMO APPEAL FLOWCHART



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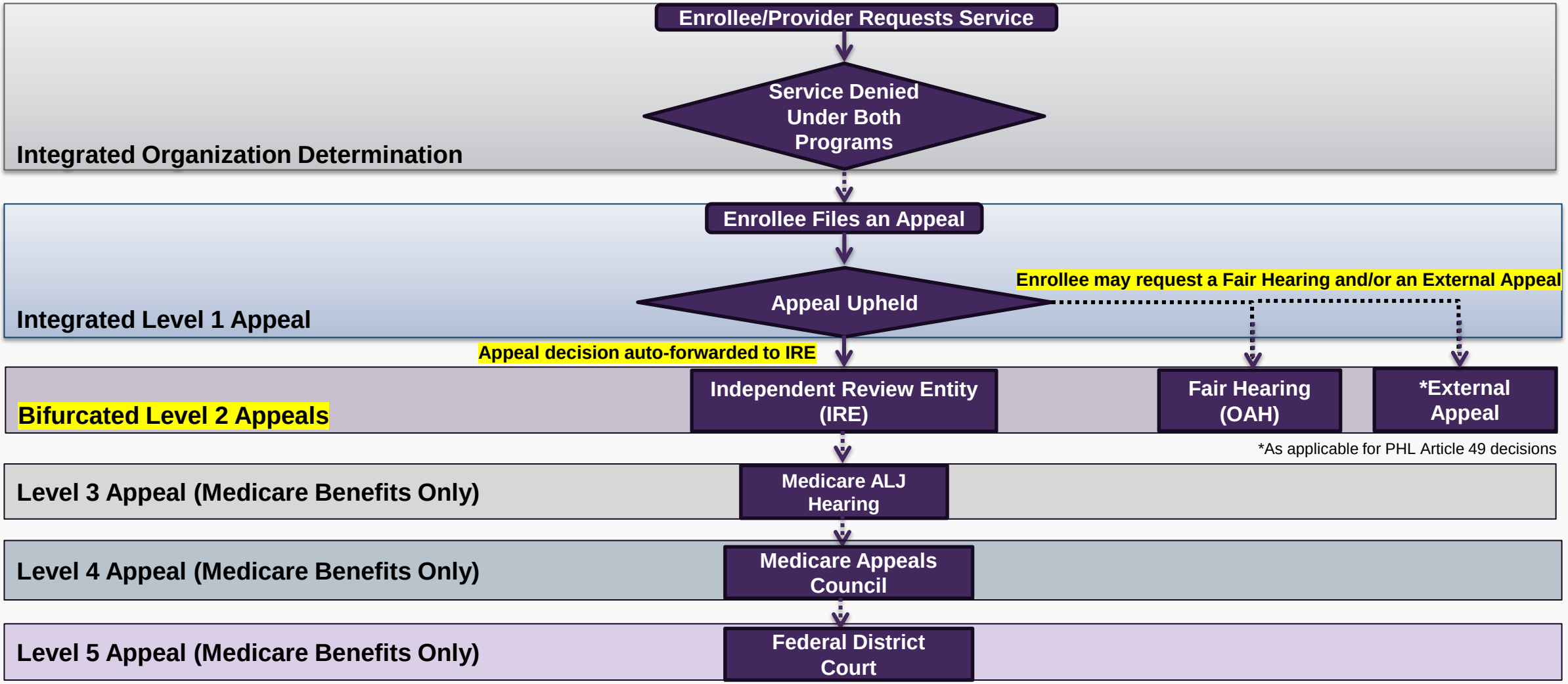
UNIFIED APPEAL FLOWCHART



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AID CONTINUING UNDER THE UNIFIED A&G PROCESS

- Enrollees can request Aid Continuing (AC) for services covered under Parts A and B of Medicare, and Medicaid.
- AC is provided by the MAP plan only if all the following occur:
  1. The enrollee files an integrated appeal;
  2. The integrated appeal involves the termination, suspension, or reduction of previously authorized services;
  3. Services were ordered by an authorized provider;
  4. The period covered by the original authorization has not expired; and
  5. The enrollee requests AC on or before the later of:
     - Within 10 calendar days of the Coverage Decision Letter notifying the enrollee of an adverse Integrated Organization Determination; or
     - The effective date of the proposed adverse Integrated Organization Determination.

Reference: 42 C.F.R. §422.632

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AID CONTINUING UNDER THE UNIFIED A&G PROCESS CONT.

- AC continues until*:
  - The enrollee withdraws the integrated reconsideration;
  - The plan issues an integrated reconsideration that is unfavorable to the enrollee related to the service that is being continued;
  - For an appeal involving Medicaid benefits:
    - The enrollee fails to request a Fair Hearing (FH) with AC within 10 calendar days of an adverse integrated reconsideration;
    - The enrollee withdraws the appeal or request for a FH; or,
    - The FH decision is issued and is adverse to the enrollee.
- For adverse Integrated Reconsiderations/FHs:
  - **MAP plans may not pursue recovery of costs of services furnished while the integrated reconsideration was pending.****
  - MAP plans may pursue recovery of costs of services furnished while the FH was pending.***

References:

*42 C.F.R. 422.632(c)

**42 C.F.R. 422.632(d)(1)

***42 C.F.R. 422.632(d)(2) and 18 NYCRR 358-3.6(d)

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UNIFIED A&G AND COMPLAINT TIMEFRAMES

Coverage	Timeframe Authorities
Medicare; Medicaid*; Medicare and Medicaid*	42 C.F.R. Part 422 (Medicare Advantage Program); PHL Article 49; PHL 4408-a; 10 NYCRR Part 98

*Updated timeframe chart to come.

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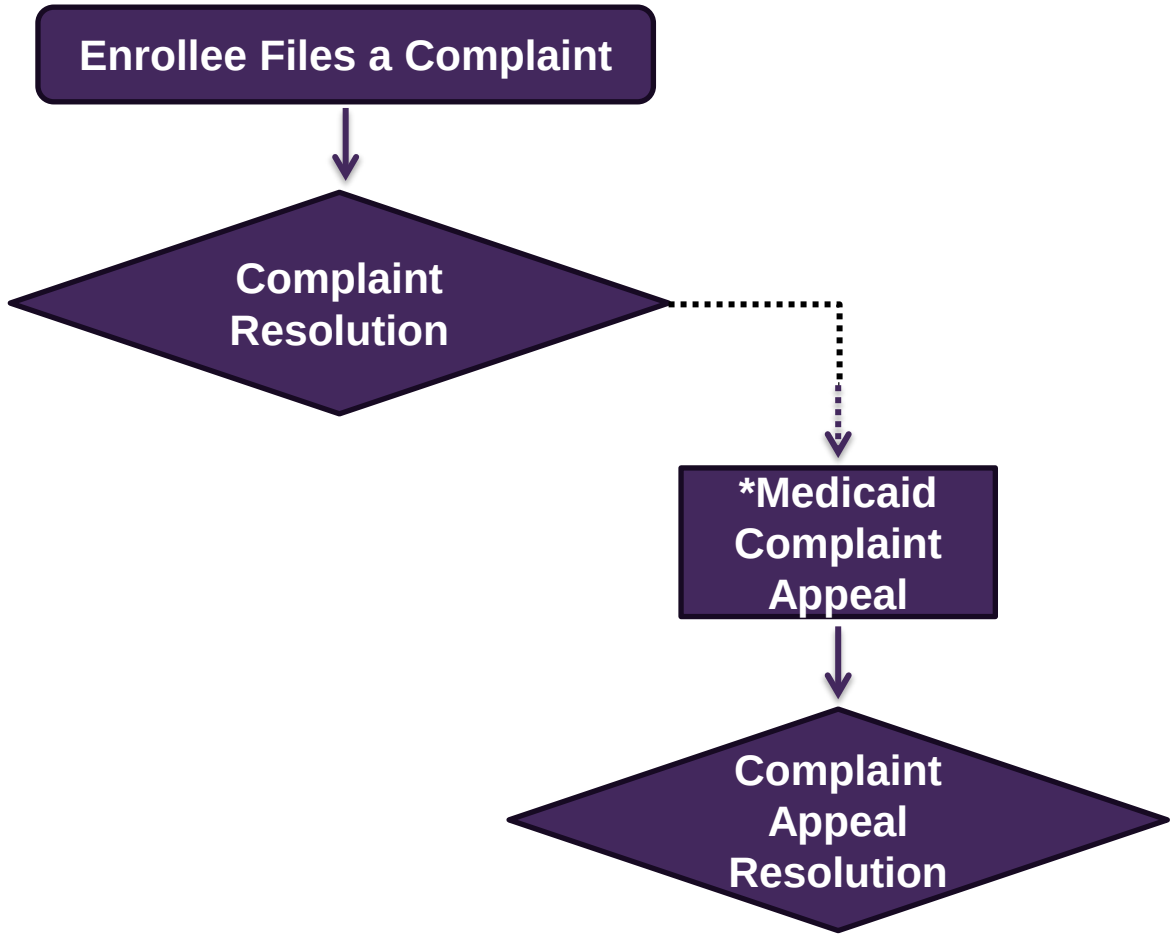
UNIFIED A&G COMPLAINT PROCESS

- Complaints are integrated at the plan level. Enrollees do not need to choose to complain with Medicare and/or Medicaid.

- For complaint determinations related to Medicaid:
  - the enrollee retains the right to file a complaint appeal pursuant to PHL 4408-a.
  - MAP plans must notice determination using the Medicaid model complaint resolution and complaint appeal notices.



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UNIFIED A & G NOTICING

Decision	CMS Letter / Department Medicaid Model Notice
Integrated Organization Determination-Approval	Department Medicaid Approval Notice
Integrated Organization Determination-Denial	CMS Coverage Decision Letter
Integrated Organization Determination-Extension of Timeframe	CMS Your Right to Make Fast Complaint Letter
Denial of an Expedited Integrated Organization Determination	CMS Your Right to Make Fast Complaint Letter
Integrated Reconsideration Determination-Approval	Department Medicaid Approval Notice
Integrated Reconsideration Determination-Denial	CMS Appeal Decision Letter
Integrated Reconsideration Determination-Extension of Timeframe	CMS Your Right to Make Fast Complaint Letter
Denial of Expedited Integrated Reconsideration	CMS Your Right to Make Fast Complaint Letter
Complaint Determination	Department Medicaid Complaint Resolution Notice
Complaint Appeal Determination	Department Medicaid Complaint Appeal Notice

REMINDERS

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UNIFIED A&G NOTICE SUBMISSION

Cover Sheet	The Member Materials Cover Sheet is available on the Department's website and is required with each notice.
Required Information	Please include the information of any previously approved notices such as the approval date, the notice unique identifier and tracking number, if applicable.
Timely Responses	Timely responses to the Department's feedback would be greatly appreciated.

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REMINDER: MAP INTEGRATED MEMBER NOTICES

- *As of 1/1/2026 MAP plans will discontinue using the NY Appeals & Grievance Demonstration specific Coverage Determination Notice, Letter About Your Right to Make a Fast Complaint and Appeal Decision Notice

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RESOURCES

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RESOURCES

Department of Health Resources

- Medicaid Model Notices
- General Info for Dually Eligibles

CMS Resources

- Unified Appeal and Grievance Info (including AIP notices)
- Parts C and D Guidance
- Addendum to the Parts C and D Guidance for AIPs
- 42 C.F.R. Part 422 Medicare Advantage Program Regulation

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QUESTIONS?
MLTCINFO@HEALTH.NY.GOV

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