NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

Medicaid Advantage Plus
Integrated Appeals & Grievance Demonstration
Phase-out Plan

August 15, 2025

Overview

Consistent with Section III.J. of the **Memorandum of Understanding (MOU) between the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (the Department) to Operate Integrated Grievance and Appeals Processes (Demonstration) for Certain Integrated Medicare and Medicaid Plans,**[1] prior to terminating the demonstration, the Department must submit a draft phase-out plan to the Center for Medicare & Medicaid Services (CMS) for approval no less than 5 months before the end date of this MOU.

The Demonstration will end effective December 31, 2025. This document provides additional detail on the content of and timeline for the phase-out plan that the Department is developing. CMS will continue to work with the Department on the policy and operational details as necessary for completing the Demonstration and the phase-out plan. Beginning January 1, 2026, the Medicaid Advantage Plus (MAP) plans will transition to the unified appeals and grievances procedures for applicable integrated plans at 42 CFR 422.629-634.

I. Timeline

Task	Due Date
1. The Department notifies Medicaid Advantage Plus (MAP) plans that the demonstration is ending 12/31/2025.	4/1/2025
2. The Department posts the phase out plan for public comment Managed Long Term Care (MLTC) (ny.gov)	6/16/2025
3. Public comment period. Comments may be sent to MLTCinfo@health.ny.gov with subject line: *MAP Integrated Appeals and Grievances demonstration winddown.*	6/16/2025 - 7/16/2025
4. The Department distributes the Annual Notice of Change (ANOC) cover letter template to MAP plans to prepare for mailing to members by 9/30/2025 (with a web site posting date of 10/15/2025). MAP plans will be instructed to add language to the Administrative Changes section of the ANOC regarding the change from integrated appeals and grievances in CY 2025 to unified appeals and grievance procedures in CY 2026. As of January 1, 2026, MAP plans will follow bifurcated Level II appeals and grievance process pathways for Medicare and Medicaid.	6/27/2025

[1] https://www.cms.gov/files/document/nyiagmou.pdf

5. The Department reviews public comments that are received.	7/16/2025 - 7/23/2025
6.The MAP plan will be required to submit the draft ANOC cover letter to the Department for approval along with the ANOC for review and approval before mailing to the member	7/16/2025
7. MAP plans submit the ANOC, Evidence of Coverage (EOC) using Chapter 9B to the Department for review.	8/1/2025
8. The Department submits phase out plan to CMS for review, including a summary of public comments received.	8/1/2025
9. CMS approves the phase out plan.	8/15/2025
10. The Department begins implementing the phase-out plan.	8/18/2025
11. The Department distributes the MAP member handbook/insert template to the MAP plans.	8/18/2025
12. MAP plans submit the MAP member handbook/insert to the Department for review via MLTC.docs@health.ny.gov.	9/1/2025
13. MAP plans distribute the Department-approved MAP member handbook/insert notice to members.	10/1/2025
14. MAP plans submit to the Department for review Form CMS-10716 Coverage Decision Letter, Letter About Your Right to Make a Fast Complaint, and Appeal Decision Letter. CMS released the Letter about Your Right to Make a Fast Complaint (ZIP) and Appeal Decision Letter (ZIP) in English and Spanish for Applicable Integrated Plans. For more information on these notices, please see the November 20, 2020 CY 2021 D-SNP Integrated Notices Memorandum (PDF). (see https://www.cms.gov/medicare/medicaid-coordination/about/dsnps)	10/1/2025
15. MAP plans begin utilizing Chapter 9B of the Evidence of Coverage (EOC).	1/1/2026
16. MAP plans begin to utilize the Form CMS-10716 Coverage Decision Letter, Letter About Your Right to Make a Fast Complaint, and Appeal Decision Letter for services requested in 2026 (see https://www.cms.gov/medicare/medicaid-coordination/about/dsnps).	1/1/2026
17. MAP plans will submit the last quarterly appeal summary report for Q4 2025 (October, November, December) to CMS and the Department.	4/21/2026
18. CMS and the Department will continue to meet monthly with New York State Office of Temporary and Disability Assistance (OTDA) until all CY 2025 Level II Appeals are processed.	Ongoing

II. Phase-out Plan

a. Appeals for services requested before the end of the Demonstration, will continue to follow the current four level integrated appeals process as noted below. Latest date for 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 day extension).
Level I: Initial appeal to the MAP plan

Level II: Appeal to the Office of Administrative Hearings (“OAH”) at OTDA
Level III: Appeal to the Medicare Appeals Council
Level IV: Appeal to Federal District Court

b. Members will be notified of the end of the Demonstration. The MAP plan will send a Department-approved member handbook/insert notice and cover letter with its CY 2026 ANOC that notifies the member that the MAP integrated appeals and grievance process will phase out at the end of 2025. The member handbook/insert notice will be incorporated into the Department MAP member handbook template (see attached).

c. The Department will provide the content of notices, including information on how beneficiary appeal rights will continue to operate during the phase-out and after the end of the Demonstration. The MAP plan will mail the Department MAP member handbook/insert to the current members.

d. All MAP plans must satisfy responsibilities imposed by the Department and close-out costs. The MAP plans and the New York State OTDA Office of Administrative Hearings will continue to process Level II Appeals initiated per the terms of the MOU in 2025.

e. The MAP plan is required to use the Annual Notice of Change (ANOC) cover letter that the Department has prepared. The ANOC cover letter will inform the member of the change from integrated appeals and grievances in CY 2025 to unified appeals and grievance procedures for CY 2026. MAP plans will then follow bifurcated Level II appeals and grievance process pathways for Medicare and Medicaid. The MAP plan will be required to submit the draft ANOC cover letter to the Department for approval along with the ANOC for review and approval before mailing to the member.

f. As of January 1, 2026 all MAP plans will discontinue using the NY Appeals & Greivance demonstration specific Coverage Determination Notice, Letter About Your Right to Make a Fast Complaint and Appeal Decision Notice.

Plan Letterhead

DRAFT

Notification for MAP Member Handbook Insert
Regarding the Unified Plan-level Appeals and Grievance Process
LETTER FROM PLAN TO MEMBERS

<Date>

<Barcode><Letter Code>
<Name>
<Address>
<City>, <State> <Zip>

Dear <MAP Member>:

This mailing is letting you know about an important update to your member handbook. The update will be available on our website at: <insert hyperlink>. Please read this update carefully. The MAP appeals and grievance process is changing. These changes take effect January 1, 2026.

The member handbook update tells you about:

1. What is changing between now and December 31, 2025?
2. What is changing on January 1, 2026?
3. Do I still get External Appeal rights for Medicaid covered benefits?
4. Where can I get more information?

A quick reference guide about these changes is attached. Please call member services at <Toll Free Number>. < add TTY info> if you:

- have any questions about this information;
- cannot access the internet to view the handbook update; or
- want to have the handbook update mailed to you.

Please keep the update with your member handbook.

[Insert Plan Signature]

[Include Taglines]

Important Change for Medicaid Advantage Plus Member Appeals

What is changing between now and December 31, 2025?

There are no changes to the Level 2 Appeal process until the end of 2025. If we deny your Level 1 Appeal (also known as a Plan Level Appeal) , your case will **automatically be sent for a Level 2 Appeal** with the Hearing Office.

What is changing on January 1, 2026?

The way you request a Level 2 Appeal will change. Beginning in January 2026, if you lose the Level 1 Plan appeal, your next appeal steps will depend on whether the service is covered by Medicare or Medicaid. We will send you a written notice called a "*Appeal Decision Letter",* which will tell you that you lost your Level 1 Appeal.

If the service is covered by Medicaid –

A Level 2 Appeal for services covered by Medicaid is also known as a Fair Hearing. Starting on January 1, 2026, if you lose your Level 1 Appeal, and the benefit is covered by Medicaid, you or your authorized representative must ask the State for a Level 2 (Fair Hearing) Appeal. You will have 120 days to ask for a Level 2 Fair Hearing Appeal.

- **How have Level 2 Appeals changed?**
  Prior to January 1, 2026, when your Level 1 Plan Appeal was denied, a Level 2 Appeal was automatically requested for you. You did not have to request a Level 2 Appeal yourself.

If we are reducing, suspending or stopping the Medicaid services you are getting right now and you want your services to stay the same while you wait for a Level 2 Fair Hearing Appeal decision, you must ask for the Level 2 Fair Hearing Appeal within 10 calendar days from the Level 1 Appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the Level 2 Fair Hearing Appeal decision. If you lose your Level 2 Fair Hearing Appeal, you may have to pay for services you got while waiting for the decision.

If the service is covered by Medicare –

If you lose your Level 1 Appeal, and the benefit is covered by Medicare, we will automatically send your case to Level 2 of the Medicare appeal process to be reviewed by an Independent Review Entity (IRE), as soon as your Level 1 appeal is complete.

If the service is covered by Medicare and Medicaid--

If you lose your Level 1 Appeal, and the benefit is covered by both Medicare and Medicaid, we will automatically send your case to the IRE, and you can also ask for a Level 2 Fair Hearing Appeal.

Do I still get External Appeal rights for Medicaid covered benefits?

Yes, if we said the service is not medically necessary, experimental or investigational, not different from care you can get in our network or available from a participating provider who has the correct training and experience to meet your needs, then you can still ask the State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will always be the final answer.

Where can I get more information?

Call member services at <Toll Free Number>. < add TTY info>. See Chapter 9 of your Evidence of Coverage (EOC) for full information about your appeal rights and how to file an appeal.

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org

Does this change to Member Appeals change my benefits or enrollment?

This change to Member Appeals does not change my benefits or enrollment.