

Appeals Processes in the Dual Eligible Demonstrations

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Introduction

In designing integrated capitated models for the dual eligible financial alignment demonstration projects, one of the most difficult issues has been creating an integrated appeals system for Medicare and Medicaid-covered services.¹ In the demonstrations, individuals who qualify for both Medicare and Medicaid benefits will receive all covered services through one managed care plan. The appeals systems for Medicare and Medicaid have developed separately with different required timeframes, different appeal procedures and different consumer protections. Achieving the twin goals of maintaining existing beneficiary protections while also simplifying the beneficiary experience has been a

¹ Background on the dual eligible demonstrations is available at www.dualsdemoadvocacy.org.

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challenge.²

This paper provides advocates with an update on how that challenge has been addressed in the appeals processes of the six states that are furthest along in the approval process for demonstrations using a capitated managed care model. It summarizes the appeals provisions in the Memorandums of Understanding (MOUs) signed between the Centers for Medicare and Medicaid Services (CMS) and California, Ohio, Illinois, Virginia and New York, and in the three-way contract (the next step after an MOU) entered into by CMS, Massachusetts and the managed care plans chosen to participate in the demonstration in that state.

All of these documents discuss integrated appeals. The states vary widely in their approaches, ranging from a New York plan to integrate appeals at all levels, to California’s approach of waiting until the demonstration has begun to identify opportunities for additional integration. Except for New York, all states allow for alternate paths for appeals above the plan level. In all states, the plan level of appeal will be integrated, except that California retains the existing separate route for appeals of personal care services for the first year of the demonstration.

This paper looks at the design of the appeals process, with particular attention to:

- Levels of appeal
- Timeframes

² An issue brief prepared by NSCLC, “Building an Integrated Appeals System for Dual Eligibles,” which discusses many of the issues in integrating appeals systems and options for resolving them, is available at www.nsclc.org/wp-content/uploads/2011/10/Building-an-Integrated-Appeals-System-for-Duals.pdf

- Aid paid pending during appeals
- Overlapping services

The paper identifies similarities and differences among the state approaches and highlights issues for advocates to raise as they work with their states on design of the demonstrations. It shows that state approaches differ in many details, with some offering significantly better protections than others around access to external decision makers, deadlines and aid paid pending (APP). It also shows that numerous details still remain to be fleshed out.

This analysis gives advocates benchmarks against which they can compare their own state’s plans for appeals processes. It also highlights areas that are particularly difficult to navigate or that need better elaboration than is found in any existing MOU.

The relevant portions of the state MOUs and the Massachusetts three-way contract are appended to this paper for reference.

1. Part D Appeals

In all states, the MOUs provide that the treatment of Part D prescription drug appeals will remain unchanged. All Part D deadlines and procedures will apply. Drugs that are not covered by Part D but are covered by Medicaid will be subject to appeal to a state fair hearing.

Advocacy Issues:

- The process for drug appeals means that even at the plan level, there is no integration on the drug side. While it is unlikely that CMS will allow integration

of the Medicare and Medicaid drug appeals process during the first year of the demonstrations, there is value in pushing for more integration as the demonstrations move forward. Designing integrated drug appeals offers opportunities to improve on the Part D model. One important improvement would be to treat denial of coverage at the pharmacy as a coverage determination that triggers appeal rights. Currently, if coverage is denied at the pharmacy, the beneficiary must take the extra step of asking for a coverage determination and then, if denied, seek an internal plan appeal.³

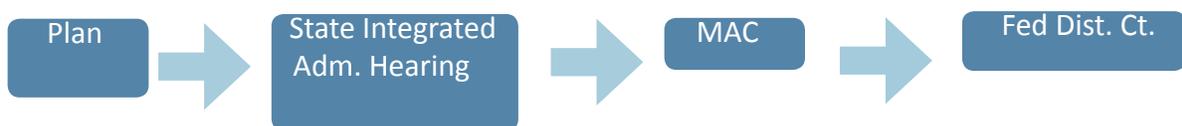
- There are cases in which a Part D appeal will result in a determination that a drug is not a “covered Part D drug” for a particular off-label use. Because Medicare and Medicaid standards for coverage of off-label drugs may differ,⁴ it is important that, in such cases, beneficiaries also get access to the Medicaid appeal system and get appropriate notices about their rights to a Medicaid coverage determination. The MOUs do not discuss how this situation would be addressed.

³ For a description of the Part D appeals process, see Ch. 18 of the Prescription Drug Benefits Manual as well as related materials found on the CMS Part D web page, www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html.

⁴ For Part D coverage, CMS requires that an off-label use be supported by a listing in one of three compendiums listed in the Medicare statute. State Medicaid agencies are permitted to also consider peer-reviewed literature in determining whether Medicaid coverage is appropriate.

The New York Appeals Process: Breaking the Mold

The New York MOU outlines an appeals system that combines Medicare and Medicaid appeals at every appeal level. Following an initial plan appeal, any adverse decision is automatically referred to an integrated administrative hearing officer, who is part of a state administrative hearing unit dedicated to handling demonstration appeals. This state hearing officer will apply both Medicare and Medicaid law, regulations and guidance. If the hearing officer’s ruling is adverse to the beneficiary, the beneficiary may appeal to the Medicare Appeals Council, where federal hearing officers also will apply both Medicare and New York Medicaid law, regulations and guidance. An adverse decision by the MAC may be appealed to federal district court. If an individual appeals a service denial at the plan level within 10 days of issuance of a denial notice, aid paid pending will be available through a decision by the Medicare Appeals Council.



2. Initial Appeals for Non-Part D Services

Timeframe for filing an appeal: Illinois, Massachusetts, Virginia and New York provide a 60-day timeframe for beneficiaries to file an appeal. California retains current Medicare (60 days) and Medicaid (90 days) timeframes at the start of the demonstration but proposes to move to 90 days in future years. Ohio allows 90 days.

Fair hearing rights: Ohio permits a beneficiary to go straight to a state fair hearing for Medicaid-covered services without first exhausting the internal plan appeal process.⁵ California also allows this option initially, but proposes integration in future years that would require exhaustion of internal plan appeals. Illinois, Massachusetts, Virginia and New York require beneficiaries to exhaust the plan’s internal appeals process before filing a state fair hearing request or other external appeal. All states require exhaustion of internal appeals for Medicare services.

Advocacy Issues:

- In Virginia, as well as some other states with MOUs pending, Medicaid managed care enrollees currently have the option of going straight to fair hearing without exhausting plan appeals. The Virginia MOU takes this right away from demonstration enrollees. Integration should

⁵ Initially, appeals in California of authorized hours for its personal care services (In-Home Supportive Services) and appeals of behavioral health service authorizations will remain unchanged, meaning they will remain outside the plan. The state proposes that in future years, with stakeholder input, it will explore ways to align the appeals process for these services.

not be achieved by eroding existing consumer protections.

- The California and Ohio MOUs, which allow direct access to a fair hearing, do not provide clarity on how overlapping services, e.g. DME, will be handled.

Aid paid pending during internal plan appeal: All of the MOUs, except California, provide for APP for all services—whether Medicare or Medicaid—during the internal plan appeal. Currently it is unclear whether California will offer APP during plan-level appeals of Medicare services. The Ohio MOU specifically adds that there will be no recoupment based on the outcome of an appeal.

The Illinois and New York MOUs state that APP will be available if an appeal is filed with the plan within 10 calendar days of notice. The 10-day filing deadline is found in Medicaid regulations,⁶ but the other state MOUs do not explicitly reference the requirement.

Advocacy Issues:

- The MOUs do not address the issue of whether an expiring authorization, for example an authorization for three months of home health care, will be subject to aid paid pending. The problem related to Medicaid managed care organizations refusing to provide APP for long-term services and supports because an authorization period has expired has been a serious ongoing concern for advocates. If not corrected in the demonstrations, the negative impact on this population—high users of LTSS—will be particularly acute.

⁶ 42 CFR 431.231(c).

- Ohio’s specific prohibition of recoupment for APP is a valuable consumer protection. Although actions to recoup APP payments after an unsuccessful appeal tend to be rare, the fear of such actions can lead beneficiaries to forego their APP rights.

Timeframe for plan resolution of internal appeal:

All states have two tracks for appeals: standard appeals and expedited appeals. The MOUs do not set the criteria for determining that an appeal must be expedited; the Massachusetts contract, however, states that the plan must use expedited timeframes if the treating physician requests them.

State	Standard appeal timeframe	Expedited timeframe
Ohio	15 days*	72 hours*
California	Applies existing Medicare (30 days) and Medicaid (30 days) timeframe requirements	Applies existing Medicare (72 hrs) and Medicaid (3 days) timeframe requirements
Illinois	15 business days	72 hours
Virginia	30 days	72 hours*
Massachusetts	30 days	72 hours*
New York	30 days#	72 hours*

* Resolution must be completed in this timeframe, or as expeditiously as the patient’s condition requires.

Seven days for a Medicaid drug appeal.

Advocacy Issues:

- Advocates should consider pushing for 15-day standard appeal timeframes for plan-level appeals. Since plans are supposed to be coordinating care and have a care team for each beneficiary, there should be less time needed to collect and analyze medical records. Enrollees benefit from the opportunity to reach an outside decision maker more quickly.
- All appeal timeframes should be stated in calendar days or hours, a practice that has been adopted by Medicare. Use of business days to set timeframes is confusing for beneficiaries and should be avoided.
- There always should be a provision requiring resolution as expeditiously as the

enrollee’s condition requires.

Presentation of evidence: The Massachusetts three-way contract provides that enrollees must be given the opportunity to present information orally or in writing during the internal appeal. The Massachusetts provision is consistent with Medicare managed care guidance, which allows in-person presentation of evidence in a plan-level appeal.⁷ The MOUs of other states do not address this issue.

Advocacy Issue:

- Making the right to oral presentation of facts and to an in-person hearing explicit in the MOU or three-way contract provides clarity. Permitting oral presentation at the plan appeal, rather than limiting evidence to the written record, can make it easier for physician to physician communication between the physician supporting the service and the reviewer.

3. First Level of External Appeal

Process/Timing: Except for New York, all MOUs provide that appeals for Medicare services are automatically forwarded to the Medicare Independent Review Entity (IRE). Medicaid-only benefits may be appealed to the state fair hearing process. In California, individuals may request an Independent Medical Review (IMR) for Medicaid-only denials or may instead go to fair hearing.

⁷ Medicare Managed Care Manual, Ch. 13 at 70.5, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf

The New York process is significantly different. Any adverse plan decision, regardless of whether it concerns a Medicare or Medicaid service, is automatically forwarded to an Integrated Administrative Hearing Officer, who is located in the State Office of Temporary and Disability Assistance, the same agency that handles state fair hearings in Medicaid. The hearing officer will decide whether the service could be covered by either Medicare or Medicaid or by both and renders a decision based on the appropriate statutes, regulations and guidance.

Appeals pathway for overlapping services: Massachusetts and Virginia say that appeals for overlapping services will be auto-forwarded to the IRE but may also be filed through the state fair hearing process. It appears that if an individual applies for a fair hearing, appeals at the IRE and at the state will both proceed, each on its own track. California defers design of the pathway for appeals of overlapping services to the three-way contract but states that the right to a fair hearing will be retained. The Ohio MOU is silent on the issue.

The Illinois MOU is unclear about the appeal path after a plan decision. It appears to permit a fair hearing request immediately after the plan denial, including a request for expedited treatment. Yet it also appears to say that, for overlapping services, a state fair hearing request may not be filed until after an IRE decision.⁸

⁸ Compare: “For services in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Medicare Part D), these services will be defined in a unified way in the Three-way Contract and as required Demonstration Plan benefits. If

The Massachusetts three-way contract adds an element not found in any of the MOUs. It provides that, when handling appeals of overlapping services, the IRE will apply both Medicare and state Medicaid standards.

In all cases, if a beneficiary receives a favorable decision from either a Medicare or a Medicaid decision-maker, the plan must provide the service.

Advocacy Issues:

- Except for New York, all the MOUs say that overlapping services will be defined in the three-way contract. However, the Massachusetts three-way contract, the only one that has been released to date, does not define what services will be treated as overlapping and what will not. The MOUs identify DME and home health as examples, but all Medicare services (other than prescription drugs), including physician and hospital services, could be defined as overlapping since they are also covered by Medicaid. More clarity is needed.

- Except for New York, the MOUs

the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or their authorized representative may **then** request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge.”

and

“For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his or her Medicaid benefits, Standard Appeals will be resolved within 90 calendar days of the Demonstration Plan’s notice of Disposition, not including the number of days the Enrollee took to file for a State Fair Hearing, and Expedited Appeals will be resolved within 3 business days from the filing of an Appeal with the State Fair Hearing Agency,” both at IL MOU, p. 76. (attached)

provide no details on how simultaneous appeals to the IRE and the state adjudicator would be handled. It could be possible, for example, to set up procedures that allow an individual to make a single submission to support both appeals. Other beneficiary-friendly steps should be considered.

Aid paid pending for overlapping services:

The New York MOU provides that, if a beneficiary originally files a plan appeal within 10 days of the notice of denial, the individual will continue to get APP through the Integrated Administrative Hearing level and on through the next level, the Medicare Appeals Council (MAC). In New York, APP rights apply regardless of whether the service is covered by Medicare or Medicaid.

The Illinois MOU requires that APP for overlap services continue until the IRE appeal decision is rendered. The IRE is the first external appeal level in Medicare. If the IRE decision is unfavorable, the individual can continue to receive APP if she requests a state fair hearing within 10 days of the IRE decision.

None of the other MOUs provide for any APP at the IRE level. Instead, if an individual wants continued services, it is necessary to request a state fair hearing within 10 days of receiving a plan denial. State policies around the availability of APP will then apply.

Advocacy Issue:

- Except for Illinois and New York, the other state MOUs appear to force individuals to go to a state fair hearing for overlapping services immediately after a plan level appeal and simultaneously pursue appeals

on both the Medicare and Medicaid side. While simultaneous appeals may expedite resolution in some cases, in others they could be confusing for beneficiaries and wasteful of state and federal administrative resources. Preserving APP regardless of the appeal route chosen by the beneficiary is a better solution.

Timeframe for resolution of first level of external appeal: New York provides that the Integrated Administrative Hearing Officer must conduct a phone or in-person hearing and provide an expedited decision within 72 hours of request and a standard decision within 90 days of request for the first year of the demonstration and 30 days of request for the second and third year of the demonstration. A standard decision for a Medicaid drug appeal must be completed within seven days of request.

Ohio provides that state hearings must resolve appeals as expeditiously as the patient’s condition requires but always within 90 days of request for the first year of the demonstration, 60 days for the second year and 30 days for the third year. The other states leave resolution timeframes to those that currently exist under Medicare and Medicaid.

Advocacy Issue:

- Ohio’s decision to use the demonstration as an opportunity to speed up current state decision timetables, at least for demonstration participants, suggests an avenue for advocacy in other states.

4. Further Levels of Appeal

New York provides that, if a beneficiary wishes to appeal an unfavorable decision by the Integrated Administrative Hearing Officer, the beneficiary may file an appeal with the Medicare Appeals Council (MAC). The MAC will review the decision using applicable Medicare and Medicaid standards. If APP had been granted at the plan level, it can continue through the conclusion of the MAC appeal. The MAC must deliver a decision within 90 days. The MAC decision can be appealed to Federal District Court.

For all other states, the procedures and timelines for further levels of appeal remain as they are currently for Medicare and Medicaid services.

5. Notices

All states require that appeal rights be described in a single integrated notice. Ohio requires a single integrated notice “specific to the service or item type in question.” Virginia requires that the notice include information on whether an individual may receive benefits pending the appeal. The Massachusetts three-way contract requires that the notice be provided at least 10 days in advance of the date of the plan’s action.

6. Training and Quality Control

The New York MOU provides that both the state and CMS will offer training to the Integrated Administrative Hearing Officer and to the MAC. Further, to validate that the Integrated Administrative Hearing Officer's decisions are supported by applicable Medicare law, regulations and coverage criteria, all its decisions during the first year of the demonstration will be reviewed by the Medicare Part C qualified independent contractor (QIC). The review is for quality assurance and feedback and does not toll decision deadlines or affect beneficiary appeal rights.

7. Conclusion

The currently available MOUs and the Massachusetts three-way contract demonstrate the complexity involved in integration of appeals in the demonstrations. It is important to spell out appeal rights with precision in order to ensure that integration does not erode existing benefits and, instead, improves beneficiary protections.

Advocates with questions about appeals in the demonstrations should contact Georgia Burke at GBurke@nscl.org.

For more information on dual eligibles demonstration projects, visit NSCLC's dual demonstration website, www.dualsdemoadvocacy.org. The site contains information and tools to help state and national advocates be more effective in representing consumers through the planning and implementation of the demonstrations.

Appeals Provisions in Current MOUs

A. California

California MOU, App. 7, pp. 99-101

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf

IX. Appeals – Other than appeals for Medicare Part D, county-authorized IHSS hours, and county-authorized behavioral health services, which shall remain unchanged, the following is the beginning of a three-year process for a unified Medicare-Medicaid appeals process:

- a. Appeals Process - Leveraging the Current System: For the first year of the Demonstration and until a new system (described below) is put in place, no changes will be made in the appeals process, with Medicare appeals and Medi-Cal appeals following the systems in place today for managed care.
 - i. As a first step, enrollees will be encouraged to take appeals to a navigation office or member services office at the health plan which will support the beneficiary in pursuing his or her appeal. Beneficiaries are not required to seek support from the plan. Consistent with building on the existing process, beneficiaries will be allowed to seek a state fair hearing at any time for Medi-Cal covered services (including IHSS). For County-authorized IHSS benefits, members must file a request for a state fair hearing to appeal the county's decision regarding authorized hours (please see complete description of IHSS appeals process below).
 - ii. Initial appeals, excluding those for county-administered IHSS or behavioral health, will be sent to the health plan: appeals must be filed within 90 days; and, for Medi-Cal, appeals must be filed within 90 days of receiving a Notice of Action (NOA) or may use the State Fair Hearing process.
 - iii. Second level appeals for Medicare benefits are automatically sent by the plan to the Medicare Independent Review Entity (IRE) if the plan upholds its initial denial. For certain Medi-Cal appeals, members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care. In most cases members must complete the health plan appeals process before requesting an IMR. An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.
 - iv. Third level appeals for Medicare benefits are made to the Office of Medicare Hearings and Appeals (OMHA). Medi-Cal-only benefits are appealed to the State fair hearing.

v. **Overlapping Services.** Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way and will have a designated appeal pathway, to be set forth in the three-way contract. An individual with an overlapping health issue will retain his/her right to a State Fair Hearing regardless of the designated appeal pathway.

vi. **Appeal time frames** - Individuals, their authorized representatives and providers will have the same number of days to file an appeal as allowed under current applicable laws.

vii. **Appeal resolution time frames** - All appeals must be resolved in timeframes allowed by current law.

viii. **Integrated Notice** - Participating Plan enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single integrated notice (except for county-authorized IHSS benefits, which are sent from the county).

ix. **To appeal the county's decision regarding authorized hours for IHSS benefits**, members must request a state fair hearing under Welfare and Institutions Code section 10950 et seq. A recipient must file a request with the county for a State Fair Hearing within 90 days after the date of county action or inaction. CDSS will commence a hearing within 30 days of the request. A CDSS Administrative Law Judge will conduct the hearing. A proposed decision must be issued within 75 days and adopted or alternated by the CDSS Director within 30 days after that.

b. **Appeals Process: Future Years** - Creating a more Integrated appeals process: To provide clarity for enrollees and providers under the demonstration's integrated benefit package, California will work with stakeholders and CMS in good faith to further integrate the appeals process based on the current Medicare Advantage appeals process as set forth at 42 CFR Part 422, Subpart M and the below working principles. The Part D appeals process will not be integrated with the Medi-Cal appeals process.

i. **Appeal time frames** - Individuals, their authorized representatives and providers will have a 90 day time-frame for requesting an appeal.

ii. **State fair hearings** would not be immediately available and beneficiaries will be required to exhaust plan and external review appeals.

iii. **There will be clear systems for:**

a) **Explicitly identifying the points at which the Participating Plan is notified of actions and**

outcomes.

b) Developing process and mechanisms by which information will be shared between the plan and the county regarding findings on the appeals for the county-administered IHSS and behavioral health benefits.

iv. Overlapping Services - Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract and as required plan benefits. Appeals related to these designated benefits will start with the health plan and proceed to either IMR or IRE. The decision of the deciding entity is controlling on the health plan. In the case of an IMR decision, it may also be appealed to the State Fair Hearing. Subject to applicable time frames, and only for Medicaid appeals, certain decisions rendered by IRE may also be appealed to State Fair Hearing.

v. Integrated Notice - Participating Plan enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single integrated notice.

vi. The state will seek additional input from stakeholders to consider options to align the appeals processes for county-authorized IHSS and behavioral health services with the integrated appeals process for all other Medicare and Medi-Cal benefits.

B. Illinois

Illinois MOU, App. 7, pp. 75-77

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf

IX. Appeals – Each Demonstration Plan must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid Appeals process:

a. Integrated/Unified Appeals Process:

i. Appeal time frames - Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have:

1. 60 calendar days from the date of notice of Action to file a Demonstration Plan Appeal;
2. 30 calendar days from the Demonstration Plan’s notice of disposition (i.e., resolution) to request a State Fair Hearing for Medicaid-only services; and
3. 30 calendar days from the notice of the right to a State Fair Hearing following the Independent Review Entity’s (IRE) adverse disposition (i.e., resolution) to request a State Fair Hearing for Medicare-Medicaid overlapping services. The Enrollee will receive notice of his or her right to request a State fair hearing from his or her Demonstration Plan and/or the State.

ii. Appeal levels -

1. All initial Appeal requests will be filed with the Demonstration Plan in accordance with applicable laws and regulations. The State will review all Demonstration Plan Appeal process policies and procedures to ensure consistency with Medicaid-required timelines.
2. Appeals for Medicare A and B services will be automatically forwarded to the Medicare Part C Independent Review Entity (IRE) if the Demonstration Plan upholds its initial denial.
3. For Medicaid-only benefits, if the resolution following the Demonstration Plan Appeal process is not wholly in favor of the Enrollee, such Enrollee or their authorized representative may request a State Fair Hearing.
4. For services in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Medicare Part D), these services will be defined in a unified way in the Three-way Contract and as required Demonstration

Plan benefits. If the resolution following the Demonstration Plan Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the Demonstration Plan. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or their authorized representative may then request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge. Any determination in favor of the Enrollee will require payment by the Demonstration Plan for the service or item in question.

iii. Appeal resolution time frames -

1. All initial Appeals must be resolved by the Demonstration Plan within 15 business days of their submission for Standard Appeals and within 24 hours of their submission for Expedited Appeals.
2. For Medicare services automatically forwarded to the IRE, the IRE must notify the Enrollee of an expedited decision within 72 hours, a pre-service decision within 30 calendar days and a payment decision within 60 calendar days.
3. For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within 90 calendar days of the filing of an Appeal with the Demonstration Plan, not including the number of days the Enrollee took to subsequently file for a State Fair Hearing, and Expedited Appeals will be resolved within 3 business days from the filing of an Appeal with the State Fair Hearing Agency.
4. For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his or her Medicaid benefits, Standard Appeals will be resolved within 90 calendar days of the Demonstration Plan's notice of Disposition, not including the number of days the Enrollee took to file for a State Fair Hearing, and Expedited Appeals will be resolved within 3 business days from the filing of an Appeal with the State Fair Hearing Agency.

iv. Continuation of Benefits Pending an Appeal -

1. All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the Demonstration Plan Appeal process. This means that such benefits will continue to be provided by providers to Enrollees, and that Demonstration Plans must continue to pay providers for providing such services pending the resolution of the Demonstration Plan Appeal process.
2. For Medicaid-only service and Medicare-Medicaid overlap service Appeals: If the request for an Appeal is filed with the Demonstration Plan within 10 calendar days of the notice of Action, services will be required to be provided pending the resolution of the Demonstration Plan Appeal process.

3. Following the Demonstration Plan Appeal process, if resolution at the Demonstration Plan level, is not wholly in favor of the Enrollee:

a. For Medicaid-only services, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the notice of disposition from the Demonstration Plan, services will be required to be provided and paid for pending the resolution of the State Fair Hearing Appeal process.

b. For appeals of Medicare-Medicaid overlap services, the Appeals will be forwarded to the IRE as discussed in IX.a.ii.4, and services will be required to be provided and paid for pending the resolution. If the resolution of the IRE is not wholly in favor of the Enrollee, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the notice of disposition from the IRE.

v. Integrated Notice - Demonstration Plan Enrollees will be notified of all applicable Demonstration, Medicare, and Medicaid Appeal and State Fair Hearing rights through a single notice jointly developed by the State and CMS.

C. Massachusetts

Massachusetts MOU, App. 7, pp. 85-86

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

IX. Appeals – Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

i. Appeal time frames - Individuals, their authorized representatives and providers will have 60 days to file an appeal related to coverage. This matches the current 60-day time-frame for requesting an appeal related to benefits under Medicare, and exceeds the current 30-day time-frame for requesting appeal related to benefits under Medicaid.

ii. Appeal levels - Initial appeals will be filed with the ICO.

1. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE). Consistent with existing rules, Part D cases will be automatically forwarded to the IRE if the Plan misses the applicable adjudication timeframe.

2. Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.

3. Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract and as required Plan benefits. Appeals related to these benefits will be auto-forwarded to the IRE, and may also be filed with the Board of Hearings.

iii. Appeal resolution time frames - All Plan appeals must be resolved (at each level) within 30 days of their submission for standard appeals and within 72 hours of their submission for expedited appeals. This excludes Part D appeals, which will be resolved in accordance with existing rules.

iv. Continuation of Benefits Pending an Appeal -

1. ICOs must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal ICO appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that ICOs must continue to pay providers for providing such services pending an internal ICO appeal. This right to aid pending

an appeal currently exists in Medicaid, but is generally not available in Medicare.

2. For all appeals filed with the Board of Hearings, Enrollees may request continuation of benefits previously authorized. MassHealth will make a determination on these requests in accordance with the Commonwealth's existing appeals policy. Part D appeals may not be filed with the Board of Hearings.

v. Integrated Notice - ICO Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single notice.

vi. In the case of a decision where both BOH and the IRE issue a ruling, the ICO shall be bound by the ruling that is most favorable to the Enrollee.

Massachusetts Three-Way Contract, pp. 108-115

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf>

2.12 Enrollee Appeals

A. General

1. All Contractors shall utilize and all Enrollees may access the existing Medicare Part D Appeals Process, as described in **Appendix F**. Consistent with existing rules, Part D Appeals will be automatically forwarded to the IRE if the Contractor misses the applicable adjudication timeframe. The Contractor must maintain written records of all Appeal activities, and notify CMS and MassHealth of all internal Appeals.

2. Integrated/Unified Non-Part D Appeals Process Overview:

a. Notice of Action – In accordance with 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Action. Such notice shall be provided at least 10 days in advance of the date of its action, in accordance with 42 C.F.R. §438.404. An Enrollee or a provider acting on behalf of an Enrollee and with the Enrollee's written consent may appeal the Contractor's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §438.402 and 42 C.F.R. §422.574, an Enrollee or provider action on behalf of an Enrollee and with the Enrollee's consent may also appeal the Contractor's delay in providing or arranging for a Covered Service.

3. Appeal time frames - As more fully detailed below, Enrollees, and/or their providers, or their authorized Appeal representatives will have 60 days to file an Appeal related to coverage and

benefits.

a. The Contractor shall acknowledge receipt of each Appeal and notify EOHHS of Board of Hearings Appeals daily.

4. Appeal levels

a. Initial Appeals (first level internal Appeal) will be filed with the Contractor.

b. Subsequent Appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the Contractor.

c. Subsequent Appeals for services covered by MassHealth only (e.g. Personal Assistance Services, Behavioral Health Diversionary Services, dental services, LTSS, and MassHealth-covered drugs excluded from Medicare Part D) may be appealed to the MassHealth Board of Hearings (Board of Hearings) after the initial plan-level Appeal has been completed.

d. Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the Contractor, and an Enrollee may also file a request for a hearing with the Board of Hearings. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

5. Part D Appeals may not be filed with the Board of Hearings.

6. Appeals related to drugs excluded from Part D that are covered by MassHealth must be filed with the Board of Hearings.

7. Appeal resolution time frames - All service Appeals must be resolved (at each level) within 30 days of their submission for standard Appeals in accordance with Section 2.12.B.3 and within 72 hours of their submission for expedited Appeals in accordance with Section 2.12.B.4.

8. Continuing Services Pending an Appeal - The Contractor must provide Continuing Services for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes in 42 C.F.R. §438.420. This means that such benefits will continue to be provided by providers to Enrollees and that the Contractors must continue to pay providers for providing such services or benefits pending an internal Appeal.

9. For all Appeals filed with the Board of Hearings, an Enrollee may request Continuing Services.

MassHealth will make a determination on continuation of services in accordance with the Commonwealth's existing Appeals policy at 130 CMR §610.036, in accordance with 42 C.F.R. §438.420.

10. The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the Appeal was pending and the Contractor, or the MassHealth Board of Hearings officer reverses a decision to deny, limit, or delay services.

11. Integrated Notice - Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice for each of the internal and external Appeals processes. The form and content of the notice must be prior approved by CMS and EOHHS. The Contractor shall notify the Enrollee of any Adverse Action at least 10 days in advance of the date of its action.

a. The notice must explain:

- (1) The action the Contractor has taken or intends to take;
- (2) The reasons for the action;
- (3) The citation to the regulations supporting such action;
- (4) The Enrollee's or the provider's right to file an Appeal;
- (5) Procedures for exercising Enrollee's rights to Appeal, including where an Enrollee can file an Appeal (at the IRE, Board of Hearings or both specifically applicable to the Contractor's action);
- (6) Circumstances under which expedited resolution is available and how to request it; and
- (7) If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal.

b. The notice must:

- (1) Use easily understood language and format, and be available in Alternative Formats that meet the accessibility needs of Enrollees. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternative Formats and how to access those formats;

- (2) Be translated for the individuals who speak Prevalent Languages; and
- (3) Include language clarifying that oral interpretation is available for all languages and how to access it.

B. Internal (Plan-level) Appeals

1. Filing an internal Appeal

a. If the Enrollee disagrees with the Contractor's decision, the Enrollee may file an internal Appeal by writing, faxing, or calling the Contractor within 60 calendar days of the receipt of the written denial notice. Any oral request for a hearing must be documented in writing. A provider acting on behalf of an Enrollee, and with the Enrollee's written consent, may file an internal Appeal. This does not affect any Appeal rights that such provider has under Medicare. An Enrollee must first exhaust the Contractor's internal Appeal process before the Enrollee can proceed with an external Appeal.

b. The Contractor shall acknowledge receipt of each Appeal.

c. The Contractor must allow the Enrollee and or a designated representative an opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records; and consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

d. The Contractor must ensure that oral inquiries seeking to appeal an action, including an expedited Appeal, are treated as Appeals and confirm those inquiries in writing, unless the enrollee or the provider requests expedited resolution.

2. Making an internal Appeal decision

The Contractor must make an internal Appeal decision within 30 days. The Contractor must afford a reasonable opportunity for the Enrollee, or a designated representative, to present information orally or in writing during the internal Appeal process. The internal Appeal decision must be made by a physician or other appropriate provider who was not involved in the initial decision and who has appropriate expertise in the field for the services at issue. The Contractor must notify the Enrollee of its internal Appeal decision in writing and, for an expedited internal Appeal, the Contractor must also make reasonable efforts to provide oral notice.

The written notice must include the elements outlined in **Section 2.12.A.11** above.

3. Standard Internal Appeal Process

a. The Contractor must notify the Enrollee of the internal Appeal decision as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the Appeal. The Contractor may extend this time frame up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension of time benefits the Enrollee. When the Contractor takes an extension, the Enrollee must be notified in writing.

b. If the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the internal Appeal (or no later than the expiration of an extension).

4. Expedited Internal Appeal Process

a. The Enrollee or their authorized representative has the right to request, orally or in writing, and receive an expedited Appeal decision affecting the Enrollee's treatment in a time-sensitive situation. The Enrollee must ask for an expedited 72-hour review when the Appeal request is made. The Enrollee need not use the words "expedited" when making the request for an urgent or fast action. The Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

b. If the Contractor decides, based on medical criteria, that the Enrollee's situation is time-sensitive, or if any physician or other provider of an Enrollee's services makes the request for the Enrollee or calls or writes in support of the request for an expedited review, the Contractor must issue a decision as expeditiously as the Enrollee's health requires, but no later than 72 hours after receiving the request. The Contractor may extend this time frame by up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension of time benefits the Enrollee. For any extension not requested by the Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay. The Contractor must make a decision as expeditiously as the Enrollee's health requires, but no later than the end of any extension period.

c. If the Contractor determines not to give the Enrollee an expedited Appeal, the Contractor must give the Enrollee prompt verbal notice followed by written confirmation within two calendar days that the Appeal will be decided within the time frame for a standard Appeal (30 calendar days).

d. If, on expedited Appeal, the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the Contractor's receipt of the Appeal (or no later than upon expiration of an extension discussed above).

C. External Appeals

1. The CMS Independent Review Entity (IRE)

a. If, on internal Appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, the Contractor shall automatically forward the case file regarding Medicare services to the CMS IRE for a new and impartial review. The IRE is contracted by CMS. For standard external Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within 30 calendar days after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

b. The CMS IRE must apply both the Medicare and MassHealth (which shall be considered supplemental services) definition for Medically Necessary Services when adjudicating the Enrollee's Appeal for Medicare and supplemental services, and must decide based on whichever definition, or combination of definitions, provides a more favorable decision for the Enrollee.

c. If the CMS IRE decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision.

d. For expedited external Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

e. If the Contractor or the Enrollee disagrees with the IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2. The MassHealth Board of Hearings

All MassHealth benefits, behavioral health diversionary services, and community-based services may be also appealed to the MassHealth Board of Hearings after the initial plan-level Appeal discussed above.

a. Whenever the Contractor sends notification to an Enrollee or his or her representative (or the representative of a deceased Enrollee's estate) of its service decision, the Contractor must include information on filing a Board of Hearings Appeal, including notice that the Enrollee, his or her representative, or the representative of a deceased Enrollee's estate have standing to be a party in the hearing. The form and content of the notification used by the Contractor must be prior approved by EOHHS and CMS. The Enrollee must submit any request for a Board of Hearings Appeal, in writing, no later than 30 calendar days from the date of mailing of the Contractor's service decision.

b. Whenever an Enrollee submits a written request for a Board of Hearings Appeal within 10 calendar days of the date of mailing of the Contractor's internal Appeal decision, the Contractor is responsible for the provision of Continuing Services, if so requested by the Enrollee during the pendency of a Board of Hearings Appeal.

c. If the Board of Hearings decides in the Enrollee's favor, the Contractor must authorize or provide the service in dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice of the Board of Hearings decision.

d. If the Contractor or the Enrollee disagrees with the BOH decision, there are further levels of Appeal available, including judicial review of the decision under M.G.L. c. 30A. The Contractor must comply with any final decision upon judicial review.

e. The Contractor must designate an appeal coordinator to act as a liaison between the Contractor and Board of Hearings.

3. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

D. Hospital Discharge Appeals

1. When an Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation called the *Important Message From Medicare About Your Rights*.

2. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.

3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The Contractor must ensure that the Enrollee receives the *Detailed Notice of Discharge (CMS-10066)*. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.
4. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.
5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.
6. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

D. Ohio

Ohio MOU, App. 7, pp. 66-68

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf

IX. Appeals – Other than Medicare Part D appeals, which shall remain unchanged, the following is the approach for an integrated Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

i. Integrated Notice - ICDS Plan Enrollees will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS.

ii. Appeal time frames - Time frames for filing appeal related to benefits will be unified.

1. Individuals, their authorized representatives and providers for Medicare service appeals will have 90 days to file an appeal related to denial or reduction or termination of authorized Medicare benefit coverage.

2. Individuals or their authorized representatives will have 90 days to file an appeal related to denial, or reduction or termination of authorized Medicaid benefits covered by the ICDS plan. ICDS Plans will be directed in the three-way contract to toll applicable time frames for Medicare service appeals that have been inappropriately made to the Bureau of State Hearings within the State instead of the plan. Such appeals will be forwarded by the Bureau of State Hearings to the ICDS Plan for a determination.

iii. Appeal levels - Enrollees will continue to have full access to the Medicare and Medicaid appeals frameworks for benefit appeals. Initial appeals for Medicare service denials, reductions and terminations will be made to the ICDS Plan; sustained decisions will be auto-forwarded to the Independent Review Entity (IRE). Initial appeals for Medicaid service denials will be made to the ICDS Plan and/or the Bureau of State Hearings. Sustained ICDS Plan decisions will not be auto-forwarded to the Bureau of State Hearings, but may be appealed by beneficiaries to the Bureau of State Hearings.

iv. Appeal resolution time frames - All appeals must be resolved by the ICDS Plan as expeditiously as the patient's condition requires, but always within 15 calendar days of request for standard appeals, and within 72 hours of request for expedited appeals. The Bureau of State Hearings will resolve appeals as expeditiously as the patient's condition requires, but always within 90 days of request for the first year of the Demonstration, 60 days of request for the 2nd year of the Demonstration, and within 30 days of request in the 3rd year. Timeframe of less than 90 days will not apply when any of the following occurs:

1.) the Bureau requests a policy/legal clarification; 2.) an act of nature or unexpected disaster causes a delay; 3.) the Bureau's receipt of the request is more than 10 days after the initial request; 4.) the beneficiary requests a delay, postponement or reschedule of the hearing; 5.) the hearing is reconvened; or 6.) the hearing record is left open pending additional information.

v. Continuation of Benefits Pending an Appeal - Continuation of all non-part D benefits will be required to be provided pending internal ICDS appeals, provided the appeal is requested to the ICDS plan within the latter of applicable timeframes for making such request or the effective date of the proposed action. As provided in 42 CFR 431.211 and 230, continuations of covered Medicaid services will continue to be required when a request is made to the Bureau of State Hearings within the applicable timeframes for making such request. This means that authorized benefits will continue to be provided by providers to beneficiaries, and that ICDS Plans must continue to pay providers for providing services pending an internal ICDS appeal or state hearing request. Payments will not be recouped based on the outcome of the appeal for services covered during pending appeals. This right to aid pending an appeal currently exists in Medicaid, but generally is not currently available in Medicare.

vi. In the case of a decision where both Bureau of State Hearings and the IRE issue a ruling, the ICDS Plan shall be bound by the ruling that is most favorable to the beneficiary.

E. Virginia

Virginia MOU, App. 7, pp. 77-79

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VAMOU.pdf

IX. Appeals – Each Participating Plan must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

A. Integrated/Unified Appeals Process:

1. Appeal time frames - Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have 60 calendar days from the date of notice of action to file an appeal in writing related to coverage. Enrollees have the option of filing an expedited appeal by telephone as currently allowed for under Medicare. This matches the current 60-day time-frame for requesting an appeal related to benefits under Medicare, and exceeds the current 30-day time-frame for requesting appeal related to benefits under Medicaid.

2. Appeal levels - Initial appeals will be filed with the Participating Plan. The filing of an internal appeal and exhaustion of the Participating Plan internal appeal process is a prerequisite to filing an external appeal to Medicare or Medicaid.

a. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE).

b. Medicaid-only benefits may be appealed to the State fair hearing process, after the Participating Plan internal appeal process is exhausted. Appeals to the external State fair hearing process must be made to the DMAS Appeals Division in writing and may be made via US Mail, fax transmission, hand-delivery or electronic transmission. The appropriate street address, electronic address and telephone fax number will be included in the unified notice of appeal rights provided at the time of enrollment and accompanying the Participating Plan internal appeals decision and set forth on the DMAS public Web site. Appeals to the external Medicaid State fair hearing process must be filed with the DMAS Appeals Division within 60 days of the date of the Participating Plan internal appeal decision, unless the time period is extended by DMAS upon a finding of “good cause” in accordance with current State fair hearing regulations.

c. Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract and as required Participating Plan benefits. Appeals related to services for which Medicare and Medicaid overlap will be auto-forwarded to the IRE, and may also

be filed through the State fair hearing process. Appeals to the external Medicaid State fair hearing process shall not be auto-forwarded to the IRE, but may be filed by the enrollee or the enrollee's authorized representative in writing in accordance with the regular requirements and timelines set forth herein.

B. Appeal resolution time frames - All Participating Plan internal appeals regarding coverage decisions must be resolved within 30 days of filing for standard appeals and within 72 hours or as expeditiously as the Enrollee's condition requires for appeals qualifying as expedited appeals. This excludes Part D appeals, which will be resolved in accordance with existing rules. External appeals filed or auto-forwarded to the Medicare external appeal process shall be heard under currently existing Medicare appeal timelines. External appeals to the Medicaid State fair hearing process shall be resolved or a decision issued within 90 days of the date of filing the appeal for the first year of the Demonstration (as defined in Figure 6-1 in Appendix 6), and within 75 days of the date of filing the appeal for the second year of the Demonstration, and within 30 days of the date of filing the appeal for subsequent years thereafter. The timeline for resolution or issuance of a decision in Medicaid external appeals may be extended for delays not caused by DMAS, in accordance with existing federal court order in *Shifflett v. Kozlowski* (W.D.Va 1994), relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays (e.g., the hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant; the appellant or representative requests to reschedule/continue the hearing; the hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence). External appeals to the Medicaid State fair hearing process that qualify as expedited appeals shall be resolved within three business days or as expeditiously as the Enrollee's condition requires, in accordance with existing Medicaid law and policy.

C. Continuation of Benefits Pending an Appeal -

1. Participating Plans must provide continuing Medicare and Medicaid benefits for all prior approved non-Medicare Part D benefits that are terminated or modified pending internal Participating Plan appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that Participating Plans must continue to pay providers for providing such services pending an internal Participating Plan appeal. This right to aid pending an appeal currently exists in Medicaid, but is generally not currently available in Medicare. Existing Medicaid rules concerning benefits pending an appeal will not change.

2. For all appeals filed through the State fair hearing process, Enrollees may request continuation of benefits previously authorized. Enrollees may qualify for continuation of benefits under certain existing criteria set forth in current regulations and policy and DMAS will make a determination on these requests in accordance with DMAS' existing regulations and

policies. Medicare Part D appeals may not be filed through the State fair hearing process.

D. Integrated Notice - Participating Plan Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights, including whether an individual may receive benefits pending the appeal, through a single notice jointly developed by the Commonwealth and CMS.

E. In the case of a decision where both the State fair hearing and the IRE issue a ruling, the Participating Plan shall be bound by the ruling that is most favorable to the Enrollee.

F. New York

New York MOU, App. 7, pp. 76-80

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf>

IX. Appeals — Other than Medicare Part D appeals, which shall remain unchanged, below is the approach for an integrated Medicare-Medicaid appeals process. CMS and NYSDOH will work to continue to coordinate grievances and appeals for all services, including those related to Part D. Additional details related to the appeals process will be further delineated in the Three-way Contract.

a. Integrated/Unified Appeals Process:

i. Integrated Notice - FIDA Demonstration Participants will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS. All notices shall be integrated and shall communicate the steps in the integrated appeals process identified herein as well as the availability of the Participant Ombudsman to assist with appeals.

ii. Integrated Appeal Process and Time Frames - Time frames for filing appeal related to benefits will be unified. There are four (4) levels of appeal.

1. **Appeal Filing Deadline.** Participants, their providers, and their representatives will have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. This first level of appeal is an internal appeal, to be decided by the FIDA Plan. The appeal must be requested within 60 calendar days of postmark date of notice of Action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 calendar days of the notice's postmark date or by the intended effective date of the Action, whichever is later.

2. **Acknowledgement of Appeal.** The FIDA Plan shall be required to send written acknowledgement of appeal to the Participant within 15 calendar days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement.

3. Timeframe for Plan Decision on Appeal. The FIDA Plan shall be required to decide the appeal and notify the Participant (and provider, as appropriate) of its decision as fast as the Participant's condition requires, but:

a. Expedited: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than within 72 hours of the receipt of the appeal.

b. Standard: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal. Benefits will continue pending an appeal in accordance with section IX.a.ii.12.

4. Extension. Up to 14-calendar day extension. An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA Plan requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited grievance if he or she disagrees with the FIDA Plan's decision to grant an extension.

5. Notification of Appeal Decision. The FIDA Plan must make a reasonable effort to provide prompt oral notice to the Participant for expedited appeals and must document those efforts. The FIDA Plan must send written notice within 2 calendar days of providing oral notice of its decision for standard and expedited appeals.

6. Automatic Administrative Hearing. Any adverse decision by the FIDA Plan is automatically forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed). Benefits will continue pending an appeal in accordance with section IX.a.ii.12. The Integrated Administrative Hearing Officer role will be jointly developed by NYSDOH and CMS. CMS and NYSDOH will provide the Integrated Administrative Hearing Officers with FIDA Demonstration specific training. This second level of appeal is external to the FIDA Plan. OTDA serving as the FIDA Administrative Hearing Unit is subject to CMS and NYSDOH joint review of OTDA readiness, including use of contractor support.

7. Notices of Automatic Administrative Hearing. The FIDA Plan shall be required to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record. The Integrated Administrative Hearing Officer shall provide the Participant with a Notice of Administrative Hearing at least

10 calendar days in advance of the hearing date.

8. Administrative Record for Administrative Hearing. The Integrated Administrative Hearing Officer shall create the administrative record at the second level of appeal and allow for requesting and receiving copies of the administrative record in accordance with 42 CFR Part 405.1042.

9. Timeframe for Decision on Administrative Hearing.

a. **Standard Timeframe:** The Integrated Administrative Hearing Officer shall conduct a phone or in-person hearing and render a decision as expeditiously as the Participant's condition requires, but always within 7 calendar days for Medicaid prescription drug coverage matters and for all other matters within 90 calendar days of request for the first year of the Demonstration and 30 calendar days of request for the 2nd and 3rd year of the Demonstration.

b. **Expedited Timeframe:** The Integrated Administrative Hearing Officer shall conduct a phone or in-person hearing to notify the Participant (and the provider, as appropriate) of the decision within 72 hours of the forwarding of the FIDA Plan's appeal decision.

c. **Decision:** The Integrated Administrative Hearing Officer shall issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other information required by applicable Federal and State requirements. Participants will be notified by the timeframes stated in section II(a)(ii)(9)(a) and (b) of this Appendix.

10. Medicare Appeals Council. If a Participant disagrees with the Integrated Administrative Hearing Officer's decision, the Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the Integrated Administrative Hearing Officer's decision. An adverse Administrative Hearing decision may be appealed to the Medicare Appeals Council within 60 calendar days. This serves as the third level of appeal. These appeals must be filed with the FIDA Administrative Hearing Unit, which will forward the request for appeal and administrative record to the Medicare Appeals Council in the manner specified in the Three-way Contract. The Medicare Appeals Council will complete a paper review and will issue a decision within 90 calendar days. Benefits will continue pending an appeal in accordance with section IX.a.ii.12. CMS and NYSDOH will provide the Administrative Appeals Judges with FIDA Demonstration specific training.

11. Federal District Court. An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which serves as the fourth level of appeal.

12. Continuation of Benefits Pending Appeal. Continuation of benefits for all prior-approved

Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original appeal is requested to the FIDA Plan within 10 calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later.

13. Validation of Integrated Administrative Hearing Officer Decisions. As part of the Administration and Oversight activities set forth in this MOU and for purposes of validating that Integrated Administrative Hearing Officer decisions are supported by applicable Medicare law, regulations and coverage criteria, all decisions related to Medicare coverage will be reviewed by the Part C qualified independent contractor (QIC) for a period not to exceed one (1) year. OTDA will be responsible for forwarding a complete paper copy of the administrative case file to the Part C QIC within two (2) days of the Integrated Administrative Hearing Officer's decision. The primary purpose of the Part C QIC's review is for quality assurance and to provide feedback to OTDA to ensure that cases are adjudicated according to Medicare rules. The Part C QIC's review does not suspend or toll the enrollee's right to request review from the Medicare Appeals Council. CMS reserves the right to make any necessary adjustments to the appeals process to assure beneficiary access to Medicare items and services.



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