

Memorandum of Understanding between the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health to Operate Integrated Grievance and Appeals Processes for Certain Integrated Medicare and Medicaid Plans

I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (“CMS”) and the State of New York, Department of Health (“State” / “NYSDOH”) will establish a Federal-State partnership to implement a New York Integrated Appeals and Grievances Demonstration (hereinafter, the “Demonstration”) to streamline and simplify the grievance and appeals processes for individuals enrolled in both Medicare and Medicaid (“dually eligible individuals”). This Federal-State partnership will implement a Demonstration that integrates appeals and grievance processes for Medicaid Advantage Plus (“MAP”) plans and Fully Integrated Dual Eligible Special Needs Plans (“FIDE SNPs”) with exclusively aligned enrollment participating in the MAP program sponsored by the same offeror (collectively, “the plans”). The Demonstration will begin January 1, 2020, and will continue until December 31, 2023 unless terminated earlier pursuant to section III.J or continued pursuant to section III.I of this Memorandum of Understanding. This Demonstration will include integrated plan-level grievance and appeals processes and a streamlined post-plan appeals process.

This Demonstration is testing integrated grievance and appeals processes that will apply to all items and services covered by participating MAP plans and MAP-participating D-SNPs other than those provided under Medicare Part D. The integrated grievance and appeals process does not apply to: 1) Medicare and Medicaid items and services that are excluded from the plans’ benefit packages; and 2) Medicare Part D benefits. MAP plans and MAP-participating D-SNPs will apply the integrated grievance process described in 42 CFR § 422.630 to all plan-level grievances, whether relating to Medicare or to Medicaid. The plans will also apply the integrated coverage determination and reconsideration process described at 42 CFR § 422.629 and §§ 422.631 through 422.634. Any modifications to the grievance and plan-level appeals rules under 42 CFR §§ 422.629-422.634 will be consistent with the flexibilities available under those rules and are described in Appendix 3 to the MOU. For appeals subsequent to the plan level, a streamlined post-plan process will replace the separate Medicare and Medicaid processes. This process will ensure all protections in statute, regulation and regulatory guidance for both Medicare and Medicaid appeals processes. The specifics of this process are described in the Appendix 3 to this MOU.

CMS and NYSDOH will provide oversight and monitoring of this integrated appeals process through an oversight team. The oversight team will collect data regarding integrated grievances and appeals from plans as needed in addition to regular Part C and Medicaid data collection. The CMS and NYSDOH team will also collect data from integrated post-plan entity (the New York Office of Temporary and Disability Assistance, “OTDA”) as described in section III.F of this MOU.

The beneficiaries eligible to participate in this Demonstration are all full benefit dually eligible individuals enrolled in the MAP and FIDE SNPs with exclusively aligned enrollment participating in the MAP program. Criteria for MAP plans and FIDE SNPs with exclusively aligned enrollment participating in the MAP program are described in section III.B of this MOU.

Key objectives of this Demonstration are to improve beneficiary experience with appeals process, as well as to generate administrative streamlining/savings for plans and state and federal agencies.

The post-plan appeals process described in Appendix 3 is informed by CMS's and the State's experience with the Fully Integrated Duals Advantage ("FIDA") and the Fully Integrated Duals Advantage for Individuals with Developmental Disabilities ("FIDA-IDD") demonstrations, which have operated as partnerships between CMS and the State from 2014 to 2019 and since 2015, respectively.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document represents the agreement between CMS and NYSDOH to operate an integrated grievance and appeals process for participating MAP plans. The appendices to this document provide the operational details of these processes and are incorporated as if set forth herein. CMS and NYSDOH may provide clarification through subsequent updates to this document and operational guidance.

III. DEMONSTRATION DESIGN / OPERATIONAL PLAN

A. *Demonstration Authority*

The following elements are part of the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

- 1. Medicare Authority:** The Medicare elements of the Demonstration shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 1. MAP plans and FIDE SNPs with exclusively aligned enrollment participating in the MAP program will continue to comply with all Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 CFR Parts 422 and 423, and applicable subregulatory guidance, as amended from time to time, except to the extent specified in this MOU.

Medicare Waiver Approval: CMS approval of Medicare waivers is reflected in Appendix 1. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the

withdrawal, together with the effective date, and afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. The demonstration will continue during the pendency of any CMS-state discussions regarding termination of the demonstration. Termination and phase out would proceed as described in section III.J of this MOU. If a waiver or expenditure authority is withdrawn, Federal financial participation ("FFP") is limited to normal closeout costs associated with terminating the waiver or expenditure authority.

2. **Medicaid Authority:** The Medicaid elements of the Demonstration shall operate according to existing Medicaid statute, regulation and regulatory guidance, including but not limited to all requirements of any Section 1115(a) demonstration and the 1915(c) waivers applicable to those MAP Participants who may be enrolled in a 1915(c) waiver. MAP Plans are required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act, 42 CFR 422.629-634 and Part 438 *et. seq.*, and applicable regulatory guidance, as amended or modified, except to the extent specified in this MOU.

B. Plans Participating in the Demonstration

Participating plans are FIDE SNPs that exclusively align with Medicaid managed care plans called MAP plans. A related organization that offers the FIDE SNP with exclusively aligned enrollment participating in the MAP program also offers the MAP plan. Both the FIDE SNPs with exclusively aligned enrollment participating in the MAP program and Medicaid MAP plans are considered participating plans for the Demonstration.

Full benefit dual eligible individuals who meet nursing facility level of care requirements and who are dually eligible in managed long-term care pursuant to §4403-f of the New York State Public Health Law enroll in two separate plans – the MAP plan and the FIDE SNP with exclusively aligned enrollment participating in the MAP program – and have their Medicare and Medicaid benefits coordinated by the same parent organization. Enrollment between the MAP plans and FIDE SNPs with exclusively aligned enrollment participating in the MAP program is aligned such that eligible individuals must enroll in both plans to participate in this integrated product.

Appendix 2 provides a list of plans eligible to participate in the demonstration as of the date of execution of this MOU.

C. Appeals Process

The specific appeals process is described in detail in Appendix 3 to this MOU. CMS and NYSDOH may make changes to this process by mutual agreement. Such changes will be documented through an updated appendix.

Internal grievances and appeals: CMS and the State agree to utilize a unified set of requirements for plan grievances and internal coverage determination and appeals processes described in 42 CFR §§ 422.629 - 422.634 and discussed in further detail in Appendix 3. All plan grievance and appeal procedures shall be subject to review and prior approval by CMS and the State. Part D

appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals and appeals for other services outside of the plan's benefit will be managed solely by NYSDOH.

Post-Plan Appeals: CMS and the State agree to utilize the streamlined post-plan appeals process described in Appendix 3. This process will build on the infrastructure developed for the FIDA demonstration and will create a more beneficiary friendly and easily navigable system. Key elements of the process include: 1) an automatic administrative hearing to review all adverse plan-level appeal decisions. The review will be performed by OTDA; 2) there will be no amount in controversy; and 3) continuation of benefits will apply during the external appeal process as described in Appendix 3. Protocols and model notices will be developed to assure coordinated access to the appeals mechanism. Part D appeals and grievances will continue to be managed under existing Part D rules.

D. Enrollment

Beneficiaries will participate in the demonstration by enrolling in a MAP plan and exclusively aligned MAP-participating D-SNP as described in Section III.B. All Medicare Advantage and NYSDOH Medicaid enrollment and disenrollment rules apply.

E. Beneficiary Materials

CMS and NYSDOH will jointly develop model plan materials that describe the integrated appeals process.

F. Administration and Reporting

All Medicare Advantage and state Medicaid reporting requirements will apply to participating plans. Any additional reporting obligations for participating plans will be described in Appendix 3 or subsequent operational guidance. CMS and the State will also develop processes for monitoring the post-plan appeals process, including collecting data from OTDA.

CMS and the State agree to designate representatives (the oversight team) to monitor the Demonstration. These representatives shall: 1) review reports from plans and OTDA; 2) confer with OTDA staff on a regular basis; and 3) meet with participating plans as needed to ensure compliance with Demonstration requirements. The oversight team will meet regularly (initially monthly) with OTDA staff to discuss topics such as the status of OTDA operations, training needs, emerging patterns or trends in the types and volume of appeals, timeliness of decisions, and/or the necessity for updates to operational guidance.

G. Financing

This demonstration will not affect Medicare Advantage rates or Medicaid rates.

H. Evaluation

CMS will fund an evaluation of the demonstration. The evaluation will assess the overall efficacy of the demonstration, including the number and cost of appeals averted, accuracy, and satisfaction of affected parties. CMS and the State will collaborate in providing information necessary to conduct the evaluation, and participating plans will provide any necessary data.

I. Extension

The State may request an extension of this Demonstration. Any extension request will be subject to CMS approval.

J. Modification

The State agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on the Demonstration.

1. **Limitations of MOU:** Other than as set forth herein, this MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States or the State of New York, their agencies, instrumentalities, or entities, their officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
2. **Modification:** Either CMS or the State may seek to modify or amend this MOU and Appendices. Any material modification shall require written agreement by both parties.
3. **Termination:** CMS and the State may terminate this MOU under the following circumstances:
 - a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 180 days advance notice to the other entity and 90 days advance notice is given to beneficiaries and the general public. Any termination will coincide with the end of a calendar year, unless CMS and the State both agree otherwise.
 - b. Termination for cause - Either CMS or the State may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU, such as failure to meet the terms described in Appendix 3.
 - c. Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures beneficiaries and plans notice and access to grievance and appeals processes that comply with Medicare Advantage and Medicaid rules.

4. **Demonstration phase-out.** Termination at the end of the Demonstration, December 31, 2023, or such other date as agreed pursuant to III.I or determined pursuant to III.J.3.a, must follow the following procedures:
 - a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than 5 months before the end date of this MOU. Prior to submitting the draft phase-out plan, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is agreed to by CMS, the phase-out activities must begin within 14 days.
 - b. Phase-out Plan Requirements – The phase-out plan must include, at a minimum:
 - 1) the process by which appeals filed before the end of the Demonstration will be adjudicated;
 - 2) how beneficiaries will be notified of the end of the Demonstration;
 - 3) the content of any notices, including information on how beneficiary appeal rights will continue to operate during the phase-out and after the end of the Demonstration; and
 - 4) any ongoing participating plan and State responsibilities and close-out costs.

K. Signatures

This MOU is effective on this day of May, 2022 through the end of the Demonstration period December 31, 2023. Additionally, the terms of this MOU shall continue to apply to the State and participating plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness whereof, CMS and the State of New York have caused this Agreement to be executed by their respective authorized officers:

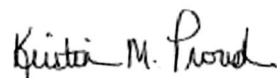
For the Centers for Medicare & Medicaid Services:

Timothy Engelhardt -S
Digitally signed by Timothy Engelhardt -S
 Date: 2022.08.08 15:46:50 -04'00'

Tim Engelhardt, Director
 Medicare-Medicaid Coordination Office
 Centers for Medicare & Medicaid Services

 Date

For the New York State Department of Health:



 Kristin Proud
 Acting Executive Deputy Commissioner

August 2, 2022
 Date

Appendix 1: Authorities and Waivers

A. Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to participating plans and their sponsoring organizations for the Demonstration period beginning no earlier than January 1, 2020 through December 31, 2023, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and closeout activities.

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to "...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid]." 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "[t]he Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Sections 1852 (f) and (g) and 1860D-4 and implementing regulations at 42 CFR Part 422, Subpart M and 42 CFR Part 423, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.

B. Medicaid Authorities and Waivers

No additional Medicaid waivers are necessary to operate this demonstration. As stated in Section III.A.2 of the MOU, the Medicaid elements of the Demonstration shall operate according to existing Medicaid law and regulation and regulatory guidance, including but not limited to all requirements of any Section 1115(a) demonstration and the 1915(c) waivers applicable to those MAP Participants who may be enrolled in a 1915(c) waiver.

Appendix 2: Criteria for Participating Plans

The plans eligible to participate in the Demonstration must offer both a MAP plan and a FIDE SNP with exclusively aligned enrollment participating in the MAP program. In other words, to participate in the Demonstration, eligible individuals must enroll in both plans.

Table 1: MAP and FIDE SNPs with exclusively aligned enrollment participating in the MAP program that are eligible to participate in the Demonstration for CY 2021

Legal Entity Name	MAP Plan Name	Name and Contract Number of FIDE SNP with Exclusively Aligned Enrollment Participating in the MAP Program
AgeWell New York, LLC.	AgeWell New York Advantage Plus	AgeWell New York Advantage Plus, Contract Number H4922-010
Centers Plan for Healthy Living, LLC.	Centers Plan for Medicaid Advantage Plus	Centers Plan for Medicaid Advantage Plus Contract Number H6988-004
Elderplan, INC.	Elderplan Plus Long-Term Care	Elderplan Plus Long Term Care, Contract Number H3347-007
Elderserve Health, Inc.	Riverspring MAP	Riverspring MAP, Contract Number H6776-002
Hamaspik, Inc.	Hamaspik Medicare Choice	Hamaspik Medicare Choice, Contract Number H0034-002
Healthfirst Health Plan, Inc.	Healthfirst CompleteCare	Healthfirst CompleteCare, Contract Number, Contract Number H3359-034
HealthPlus HP, LLC.	Empire MediBlue HealthPlus Dual Plus (HMO D-SNP)	Empire MediBlue HealthPlus Dual Plus, Contract Number H1732-001
Integra MLTC, Inc.	Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP)	Integra Synergy Medicaid Advantage Plus, Contract Number H1205-006
MetroPlus HealthPlan Inc.	MetroPlus Ultra Care	MetroPlus Ultra Care, Contract Number H0423-007
New York Quality Healthcare Corporation	Fidelis Medicaid Advantage Plus (HMO D-SNP)	Fidelis Medicaid Advantage Plus, Contract Number H5599-003/008
Senior Whole Health of New York, Inc.	Senior Whole Health of New York NHC	Senior Whole Health of New York NHC, Contract Number H5992-007

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Legal Entity Name	MAP Plan Name	Name and Contract Number of FIDE SNP with Exclusively Aligned Enrollment Participating in the MAP Program
Village Senior Services Corporation	VillageCareMAX Medicare Total Advantage	VillageCareMAX Medicare Total Advantage, Contract Number, H2168-002
VNSNY CHOICE	VNSNY CHOICE Total Plan	VNS CHOICE Total, Contract Number, H5549-003

NYSDOH and CMS may by mutual agreement add additional plans eligible to participate in the Demonstration.

Appendix 3: Grievance and appeal processes

- 3.1. Grievances: The integrated grievance procedures described in 42 CFR § 422.630 will apply to all plans participating in this demonstration. Participating plans will also comply with all record-keeping and procedural requirements included in their contracts with CMS and NYSDOH. “Grievance appeals” as described in the MAP enrollee handbook remain available for Medicaid-related grievances.
- 3.2. Appeals Process Overview:
- 3.2.1. Part D appeals process: All participating plans shall utilize and all members may access the existing Part D appeals process. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Part D independent review entity (IRE) if the participating plan misses the applicable adjudication time frame. The Part D IRE is contracted by CMS.
- 3.2.2. Organizational Determinations
- 3.2.2.1. Process: The integrated organizational determination procedures described in 42 CFR § 422.631 will apply to all plans participating in the demonstration with any modifications to that process described in this Appendix.
- 3.2.2.2. Integrated coverage determination notice: Participating plans will provide members with written notice of any adverse action by use of single notice specific to the item or service type in question, approved jointly by CMS and the State. The notice will comply with all requirements of 42 CFR § 422.631(d).
- 3.2.2.3. Timeframe for advance notice: When advance notice is required, participating plans shall provide members with an integrated coverage determination notice at least 15 days in advance of the effective date of the adverse organizational determination.
- 3.2.3. Levels of appeal: The integrated appeal process has four (4) levels of appeal subsequent to the integrated organizational determination: 1) the initial appeal to the participating plan (called the integrated reconsideration); 2) appeal to the Office of Administrative Hearings (“OAH”) at OTDA; 3) appeal to the Medicare Appeals Council; and 4) appeal to Federal District Court. Each of these levels is discussed in further detail below.
- 3.2.4. Continuation of benefits pending appeal: benefits will continue during the integrated reconsideration process consistent with 42 CFR § 422.632 and State statutes, regulations and regulatory guidance. In addition, benefits will continue for all services during the post-plan review as described below in section 3.11.

3.2.5. Out-of-network providers: Out-of-network providers may use the integrated appeals process on their own behalf for services provided to enrollees of Participating plans. To proceed with an appeal, out-of-network providers must complete a Waiver of Liability using the form required by NYSDOH and CMS.

3.3. Internal appeals: Participating plans shall follow the procedures for integrated reconsiderations described at 42 CFR § 422.633 with the following additional requirements:

3.3.1. Acknowledgement of appeal: Participating plans will send written acknowledgment of the appeal to the member within fifteen (15) calendar days of receipt of the appeal. If a decision on the appeal is reached before the written acknowledgment is sent, the participating plan will not send the written acknowledgment.

3.3.2. The notification requirements at 42 CFR § 422.633(f)(4)(ii) pertaining to further levels of appeal shall explain the subsequent levels of the integrated appeals process, including the process and time frame for the hearing before OAH. If the member is receiving continuing benefits pending appeal, the notice must inform the member that these services will continue while the case is pending before OTDA and that even if the participating plan's action is upheld by OAH, the member shall not be liable for the cost of any continued benefits.

3.4. External appeals

3.4.1. Automatic Administrative hearing: Any wholly or partially adverse decision by the participating plan is automatically forwarded along with the appeal review record to the OAH at OTDA.

3.4.1.1. The case and case file must be auto-forwarded within two (2) business days of the adverse decision being reached.

3.4.1.2. This must be done electronically by secure and appropriate email to a designated mailbox with a cover note that clearly indicates:

3.4.1.2.1. The name of the participating plan;

3.4.1.2.2. Whether an expedited appeal is appropriate because the plan has determined, or the provider has indicated, that taking the time for a standard resolution could seriously jeopardize an enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function;

3.4.1.2.3. The type of coverage at issue (e.g., inpatient hospital care, personal care services, dentistry, nutritional supplement, or other);

3.4.1.2.4. The name, telephone number, Email address, and mailing address of the contact person at the participating plan;

3.4.1.2.5. The member's name, address, Email, phone number or other contact, and Medicaid or CIN number;

- 3.4.1.2.6. If applicable, the member's representative's name, address, Email, phone number or other contact, and a copy of any written authorization by the member; and
- 3.4.1.2.7. Other administrative requirements promulgated by OAH from time to time.
- 3.4.1.3. The administrative hearing process will comply with the state fair hearing regulations at 42 CFR § 431 subpart E.
- 3.4.2. The automatic administrative hearing occurs regardless of the amount in controversy (i.e. there will be no amount in controversy minimum imposed for matters before OTDA).
- 3.4.3. Benefits will continue pending an appeal in accordance with section 3.11.
- 3.4.4. The participating plan shall notify the member that an appeal was sent to OTDA. The notice shall also indicate that once OTDA receives the notice from the participating plan, OTDA will contact the member regarding the hearing date and also that the member should contact OTDA in the event that he/she does not hear from OTDA to schedule the hearing within:
 - 3.4.4.1. Twenty-four (24) hours for expedited appeals, which are cases that were expedited at the internal appeal level consistent with 42 CFR § 422.633(e); and
 - 3.4.4.2. Ten (10) calendar days for all other appeals.

3.5. Notices of Automatic Administrative Hearing

- 3.5.1. Acknowledgement. The participating plan shall be required to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within fourteen (14) calendar days of forwarding the administrative record with a copy to OAH. If a decision is reached before the written acknowledgement is sent, the participating plan will not send the written acknowledgement.
- 3.5.2. Hearing Notice. OAH shall provide the member and the participating plan with a Notice of Administrative Hearing at least ten (10) calendar days in advance of the hearing date. If OAH determines that the due process rights of either party, or the totality of the circumstances, require a video-teleconference or in-person hearing, OAH shall schedule the hearing for the appropriate setting. If OAH determines that a video-teleconference or in-person hearing is needed after issuing a Notice of Administrative Hearing, OAH shall issue a new Notice of Administrative Hearing with the appropriate setting and update the hearing date if needed to provide such notice at least ten (10) calendar days in advance of the hearing. DOH and CMS may issue further guidance for the determination of when to perform video-teleconference or in-person hearings..
- 3.5.3. Participation in the Administrative Hearing. The participating plan may waive its participation in the Administrative Hearing and may submit a written statement along with its waiver of participation. A copy of the statement must also be provided to the member. If the plan chooses to participate, the staff person participating must be knowledgeable in the appeal decision reached by the participating plan and the basis for the decision. The participating plan shall follow all OAH processes and procedures. OAH will not draw any adverse inference from

a participating plan's waiver of participation unless a plan is unable or unwilling to participate by telephone when requested to do so by OAH.

- 3.5.4. Administrative Record for Administrative Hearing. OAH 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 C.F.R. § 405.1042.

3.6. Time Frame for Decision on Administrative Hearing.

- 3.6.1. Standard Time Frame: OAH shall conduct a hearing and render a decision as expeditiously as the member's condition requires, but always within ninety (90) calendar days after the date the Member requests an appeal with the participating plan, excluding the days between the date the adverse appeal decision is issued and the date the adverse appeal decision is auto-forwarded to OAH in accordance with 3.4.1.2. Cases involving appeals for Medicare Part B drugs will be resolved in a timeframe consistent with the timeframe employed by the Medicare Independent Review Entity for those items. Continuances or adjournments permitted in accordance with 42 CFR 431.244(f)(4) and any successor rules or regulations do not count towards this time frame.
- 3.6.2. Expedited Time Frame: OAH shall conduct a hearing and notify the member (and the Provider, as appropriate) of the decision via phone within as expeditiously as the member's health condition requires, but no later than three working days of the forwarding of the participating plan's appeal decision and the appeal review record. If the member does not appear for a scheduled expedited hearing, the OAH will provide notice of an opportunity to reschedule. If the member requests an adjournment of the scheduled expedited hearing, the matter will be rescheduled at a time agreed to by the member.
- 3.6.3. Decision: OAH 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 appeal, the filing timeframes, and other information required by applicable Federal requirements including 42 CFR § 431.244. Members will be notified within the time frames stated in Sections 3.6.1 and 3.6.2. The participating plan is bound by the OAH decision and may not seek further review. The participating plan must implement the OAH decision immediately (within no more than one (1) Business Day).
- 3.6.4. The timeframes described herein shall not be construed to take precedence over, or limit in any way, any extension of timeframes pursuant to 42 CFR § 431.244(f).

3.7. Medicare Appeals Council.

- 3.7.1. If a member disagrees with the OAH decision, the member may appeal that decision further to the Medicare Appeals Council (MAC), which may overturn the decision. This serves as the third level of appeal. Cases appealed to the MAC will be reviewed on the basis of the record compiled by OAH, and, upon request by the MAC, any supplemental record or argument submitted by the parties to the appeal.

The Medicare Appeals Council will apply all Medicare and Medicaid coverage rules as specified in the MAP plan's Member Handbook and the model contract between the participating plan and DOH, as well as the Evidence of Coverage of the exclusively aligned MAP-participating D-SNP.

3.7.2. Medicare Appeals Council Appeal Process

- 3.7.2.1. A member must appeal an adverse OAH decision within sixty (60) calendar days of the date of the written decision.
- 3.7.2.2. The member will submit his/her request for Medicare Appeals Council review to OAH. OAH will forward the appeal and the record to the Medicare Appeals Council.
- 3.7.2.3. The Medicare Appeals Council will complete a paper review and will issue a decision within ninety (90) calendar days from the receipt of the appeal request.
- 3.7.2.4. Benefits will continue pending an Appeal in accordance with Section 3.11.
- 3.7.2.5. Participating plans may not appeal OAH decisions to the Medicare Appeals Council.

3.8. Federal District Court Reviews

- 3.8.1. Adverse Medicare Appeals Council decisions may be appealed to Federal District Court consistent with procedures described in 42 C.F.R. § 422.612. This serves as the fourth level of appeal.
- 3.8.2. There is no right to appeal to Federal Court without first exhausting an appeal through the Medicare Appeals Council.

3.9. Validation of Medicare Appeals Council and Office of Administrative Hearings Decisions. CMS and NYSDOH, through the Oversight Team, will conduct a quality oversight process for the integrated appeal system. As part of this quality review process, a participating plan may be directed to forward a sample of cases for a retrospective review. This process will be further described in subsequent guidance and will not alter the integrated appeals process set forth in this MOU.

3.10. Continuation of Benefits Pending Appeal.

- 3.10.1. Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal participating plan appeals, second level appeals at OAH, and third level appeals at Medicare Appeals Council must be provided if the original appeal is requested to the participating plan within ten (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.
- 3.10.2. In the case of an appeal to the Medicare Appeals Council, the member must have received continuation of benefits during earlier level of appeals and file the appeal with OAH within ten (10) calendar days of the OAH decision in order to receive

continuation of benefits during the appeal to the Medicare Appeals Council. If the participating plan's Action is upheld, the member shall not be liable for the cost of any continued benefits.

3.11. Effectuation of decisions:

- 3.11.1. In lieu of the timeframe described in 42 CFR § 422.634(d), the participating plan must authorize or provide the disputed services immediately (within no more than one (1) Business Day), and as expeditiously as the member's health condition requires, if the services were not furnished while pending the participating plan, OAH, or MAC decision on the appeal.
- 3.11.2. The participating plan must pay for the disputed services, in accordance with State policy and regulations, if the participating plan or OAH reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

3.12. Additional provisions for participating plans

- 3.12.1. A participating plan shall provide each member with information about the availability of the state ombudsman program ("ICAN") to assist the member in filing and pursuing an appeal.
- 3.12.2. In addition to complying with all recordkeeping requirements under 42 CFR § 422.629(h), participating plans shall inform CMS and NYSDOH of all internal appeals in a manner to be specified by CMS and NYSDOH.
- 3.12.3. The state and CMS will provide participating plans with required form notices to use in the initial appeal process. These notices shall be integrated and shall communicate the steps in the demonstration integrated appeals process as well as the availability of the member ombudsman to assist the member in the appeals process. Participating plans must use the required form notices.
- 3.12.4. In addition to complying with all Medicare Advantage and Medicaid managed care translation and interpretation requirements, participating plans will also comply with translation and interpretation requirements for MAP plans as specified in the MAP contract.

3.13. Other Medicare appeal rights

- 3.13.1. Requirements at 42 CFR §§ 422.620 – 422.622 pertaining to hospital discharge rights will continue to apply to participating plans.
- 3.13.2. Requirements at 42 CFR §§ 422.624 – 422.626 pertaining to comprehensive outpatient rehabilitation facility ("CORF"), skilled nursing facility ("SNF"), or home health benefits, will continue to apply to participating plans.