2023 California Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNP) Integrated Appeals and Grievances

Comparison of Requirements

December 2022

Note: Medicare **Part D** process and timing are not included in the integrated appeals and grievance demo, and thus plans should follow all existing Part D requirements.

Requirement	Integrated Appeals and Grievance regulations (42 CFR §§ 422.629-634)	Cal MediConnect	Medicare Advantage (non-integrated regulations)	California Medi-Cal
Grievances- general governing requirements	The integrated grievance procedures for applicable integrated plans, see 42 CFR § 422.630, Health & Safety Code (HSC) § 1368.	Three way contract Section 2.14, Medicare and Medicaid regulations	Medicare managed care regulations, see 42 CFR § 422.564	Medicaid managed care regulations, see 42 CFR § 438.400-416, HSC § 1368.
Grievances- filing	Enrollee can file at any time, see 42 CFR § 422.630(b)	Enrollee can file at any time, see three-way contract 2.14.2	Enrollee must file within 60 days of the event or incident, see 42 CFR § 422.564(d)(2)	Enrollee can file at any time, see 42 CFR § 438.402(c)(2)(i)
Availability of expedited grievances	Expedited grievances are available, see 42 CFR § 422.630(d)	Expedited grievances are available, see three-way contract 2.14.2.1.3.4, and 2.15.3.4.2	Expedited grievances are available, see 42 CFR § 422.564(f)	Expedited grievances are available involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01
Grievances- acknowledgement	Plans must send an acknowledgement of integrated grievances filed by enrollees within five (5) calendar days, see 42 CFR	Plans must send an acknowledgement of grievances filed by enrollees, see three-way contract	No requirement to send an acknowledge for grievances	Plans must acknowledge receipt of grievances, see 42 CFR § 438.406(b)(1), HSC § 1368(a)(4)(A)

Requirement	Integrated Appeals and Grievance regulations (42 CFR §§ 422.629-634)	Cal MediConnect	Medicare Advantage (non-integrated regulations)	California Medi-Cal
	§ 422.629(g), HSC § 1368(a)(4)(A)	2.14.2.1.3.1, and 2.15.3.4.2		
Grievances-resolution and timeframes	Standard integrated grievances: Plans must resolve and respond as expeditiously as required but no later than 30 calendar days from the date it receives the integrated grievance. Expedited integrated grievances: Plans must resolve and respond within 24 hours. See 42 CFR § 422.630	Standard grievances: Plans must resolve and respond as expeditiously as required but no later than 30 calendar days from the date it receives the integrated grievance, see three-way contract 2.14.2.1.3.3 Expedited grievances: Plans must resolve and respond within 24 hours, see three-way contract 2.14.2.1.3.4	Standard grievances: Plans must resolve and respond as expeditiously as required but no later than 30 calendar days from the date it receives the integrated grievance. Expedited grievances: Plans must resolve and respond within 24 hours. See 42 CFR § 422.564	Standard grievances: Plans must resolve and respond as expeditiously as required but no later than 30 calendar days from the date it receives the grievance. Expedited grievances: Plans must resolve and respond within 72 hours. See HSC § 1368.01(b)
Timeframe for advance notice prior to terminating, suspending, or reducing a previously approved item or service	Plans must provide enrollees with an integrated organization determination notice at least ten (10) calendar days in advance of the effective date of the adverse organization determination. 42 CFR § 422.631(d)(2)(i)(A)	Plans must provide enrollees with an integrated coverage determination notice at least ten (10) days in advance of the effective date of the adverse organizational determination. see three-way contract 2.15.1	N/A	Plans must provide notice at least ten (10) calendar days in advance of the effective date of the adverse benefit determination except as permitted under 42 CFR §§ 438.404(c), 431.211, 431.213 and 431.214.

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Continuation of benefits- Enrollee requests	Enrollee must request continuation of benefits for previously-approved **Medicare and/or Medicaid** benefits that the plans is terminating, suspending, or reducing within ten (10) calendar days of the notice's postmark date (i.e. the notice letting the enrollee know of the change to the service) or by the intended effective date of the Action, whichever is later, see 42 CFR § 422.632(a)	Enrollee must request continuation of benefits for previously-approved **Medicare and/or Medicaid** benefits that the plans is terminating, suspending, or reducing within ten (10) calendar days of the notice's postmark date (i.e. the notice letting the enrollee know of the change to the service) or by the intended effective date of the Action, whichever is later, see three-way contract 2.15.1.1.7 and 2.15.5	N/A	Enrollee must request continuation of benefits within ten (10) calendar days of the notice's postmark date (i.e. the notice of the change to the service or item) or by the intended effective date of the Action, whichever is later. See 42 CFR § 438.420(a)
Integrated organization determinations/coverage determinations- timing of plan decisions NOT including Part B drugs (for Part B drugs see row below)	Plans must make: **Standard integrated organization determinations** and provide notice as expeditiously as the Enrollee's health condition requires, no later than 14 calendar days from when it receives the request, See 42 CFR § 422.631(d)(2)(i)(B), HSC § 1367.01(h)(1)	The plan must: **Standard authorization decisions:** provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably	Plans must make: **Standard organization determinations** provide notice as expeditiously as the Enrollee's health condition requires, no later than 14 calendar days from when it receives the request.	Plans must make: **Standard authorization decisions** no later than 14 calendar days following receipt of the request for service. Knox-Keene plans: Per HSC § 1367.01(h)(1), standard UM decisions are to be made within five (5) business days from the

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	Knox-Keene plans: Standard organization determinations (UM decisions) are to be made within five (5) business days from the plan's receipt of information reasonably necessary to make the determination and no later than 14 calendar days from when it receives the request. **Expedited integrated organization determinations** and provide notice as expeditiously as the Enrollee's health condition requires, no later than 72 hours from when it receives the request. See 42 CFR § 422.631(d)(2)(iv), HSC § 1367.01(h)(2) **Extensions:** The plan may not extend the deadlines for integrated organization determinations.	necessary to render a decision, and in all circumstances no later than 14 calendar days after receipt of the request for service, see three-way contract 2.11.5.6.1.2 **Expedited authorization decisions**: plans must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. see three-way contract 2.11.5.6.2.1 and 2.11.5.6.2.2 **Extensions:** provide notice as expeditiously as the Enrollee's health condition requires, possible extension of	See 42 CFR § 422.568(b) and **Expedited organization determinations** provide notice as expeditiously as the Enrollee's health condition requires, no later than 72 hours from when it receives the request. See 42 CFR § 422.572(a) **Extensions:** The plan may extend the above deadlines by 14 calendar days, see 42 CFR §§ 422.568(b)(1), 422.572(b)	plan's receipt of information reasonably necessary to make the determination, and no later than 14 calendar days from when it receives the request. **Expedited authorization decisions** provide notice as expeditiously as the Enrollee's health condition requires, no later than 72 hours after receipt of the request for service Knox-Keene plans: Per HSC § 1367.01(h)(2): Expedited UM decisions are to be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours. **Extensions:** provide notice as expeditiously as the Enrollee's health condition requires, possible extension of the above timeframes of up to 14 additional calendar days, see 42 CFR §§ 438.210(d) and 438.404. Knox-Keene

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		the above timeframes of up to 14 additional calendar days. see three-way contract 2.11.5.6.1 for additional requirements.		licensed plans may not extend the deadlines for organization determinations.
Timing for Medicare Part B drugs authorization requests and appeals	General Medicare Managed Care Part B drug regulations apply, See 42 CFR §§ 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c) and 422.590 (e)(2) apply. (See 42 CFR 422.631(a) and 422.633(f)) for application to integrated plans, which cross reference the Medicare Advantage regulations).[1]	General Medicare managed care Part B drug regulations apply, See 42 CFR §§ 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), and 422.590(c) & (e)(2).	General Medicare managed care Part B drug regulations apply, See 42 CFR §§ 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), and 422.590(c) & (e)(2).	Not applicable.
Appeals-acknowledgement	Plans must send each Enrollee written acknowledgement within five (5) calendar days of receipt of **ALL** appeals, see 42 CFR § 422.629(g), HSC § 1368(a)(4)(A).	Medi-Cal appeals: Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgement to the Enrollee within	N/A	Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgement to the Enrollee within 5 calendar days of receipt. See 42 CFR

[1] Medicare Advantage for Part B drugs:

Standard organization determinations for Part B drugs must be made as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request. (see 42 CFR 422.568(b)(2)).

Expedited organization determinations must be made as expeditiously as the enrollee's health condition requires 24 hours after receiving the request.

For **reconsiderations**: the plan must make standard reconsiderations for Part B drugs as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it receives the request for a standard reconsideration (see 42 CFR 422.590(c)); and must make expedited reconsiderations as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request (see 42 CFR 422.590(e)).

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		five (5) calendar days of receipt. see three-way contract 2.15.3.3.1		§ 438.406(b)(1), HSC § 1368(a)(4)(A).
Appeals - Medicaid External Appeals	Knox-Keene plans: External Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with HSC § 1374.30) and the regulations promulgated thereunder for Medicaid second level appeals (will be in SMAC)	Knox-Keene plans: External Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with HSC § 1374.30) and the regulations promulgated thereunder, see three-way contract 2.15.3.4.3 and 2.15.3.9	N/A	External Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with HSC § 1374.30) and the regulations promulgated thereunder
Integrated Reconsiderations (Appeals)- timing of plan decision	**Standard integrated reconsiderations (appeals):** As expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days to resolve, see 42 CFR § 422.633(f)(1). **Expedited integrated reconsiderations (appeals):** As expeditiously as the Enrollee's health condition requires, or in the case of an	**Standard appeal:** As expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day the plan receives the Appeal. see three-way contract 2.15.1.2.2 **Expedited appeal:** As expeditiously as	**Standard reconsiderations (appeals):** As expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) days to resolve a standard pre-service appeal, and 60 days for cases involving request for payment.	**Standard appeals:** As expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) days. See 42 CFR § 438.408(b)(2), HSC § 1367.01(a) **Expedited appeals:** As expeditiously as the Enrollee's health condition requires, or in the case of an expedited Appeal within

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	expedited Appeal within seventy-two (72) hours, see 42 CFR § 422.633(f)(2). **Extensions:** Extensions are not permitted for integrated reconsiderations (appeals) of Medicare and Medicaid services. Plans need to ensure they are obtaining all relevant information needed to make a decision within the required timeframes.	the Enrollee's health condition requires, or in the case of an expedited Appeal within seventy-two (72) hours. see three-way contract 2.15.1.2 and 2.15.3.5.4. **Extensions:** Plans without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days. See 2.15.1.3, and 2.15.3.5.5 for additional requirements	**Expedited reconsiderations (appeals):** As expeditiously as the Enrollee's health condition requires, or in the case of an expedited Appeal within seventy-two (72) hours. **Extensions:** The plan may extend the above deadlines by 14 calendar days under certain circumstances. See 42 CFR § 422.590(a), (b), (d) and (e).	three calendar days, per HSC § 1368.01(b). See 42 CFR § 438.408(b)(3) **Extensions:** Extensions are not permitted. All Medicaid plans must resolve standard appeals within 30 days, per HSC § 1368.01(a)
Notice: Coverage Decision Letter/IDN/initial adverse determination	Coverage Decision Letter-integrated; sent for plan decisions in all Medicare and Medicaid (and overlap) cases Sent when the plan issues a full or partial denial of an integrated organization determination, after considering both Medicare and Medicaid coverage criteria. Posted online at:	Integrated Notice of Action (Knox-Keene and non-Knox Keene versions) sent when the plan issues, after considering both Medicare and Medicaid coverage criteria, a full or partial denial of an organization determination, see three-way contract 2.15.1	Integrated Denial Notice (IDN)	The Notice of Action (NOA) letter is sent for all plan decisions involving initial adverse benefit determinations. This is sent when the plan issues a full or partial denial, delay, modification, or termination decision, after considering Medicaid coverage criteria. The NOA templates are posted online and attached

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	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs			to All Plan Letter (APL) 21-011: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
Other notices	In addition to the Coverage Decision Letter, there are two (2) model notices • Letter about Your Right to Make a Fast Complaint. Not required, but meets the requirements of 42 CFR 422.631 and 422.633 when the plan makes a decision on or after January 1, 2021 to 1) extend the timeframe for deciding an integrated organization determination or integrated reconsideration, or 2) deny a request for an expedited integrated organization determination or integrated reconsideration. • Appeal Decision Letter. Not required, but meets the requirements of 42 CFR 422.633, explaining the enrollee's further appeal rights under both the	No other model notices	No other current model notices	• Notice of resolution of complaint appeal • Appeal denial notices (one version for previously authorized services or items that are being reduced, stopped or terminated, one version for other cases) • Notice of Action: Carve-Out (sent to the Enrollee when the provider cannot provide the care requested due to the service being carved out and refers the member to a different provider) • Notice of Action Your Rights (letter about the Enrollee's rights to an appeal, independent medical review, and state hearing) Notice of Appeal Resolution Your Rights (letter about the Enrollee's

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	Medicare and the state Medicaid program. Both are posted online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs			right to an independent medical review and state hearing)
Out of Network Providers	Out-of-network providers may use the integrated appeals process on their own behalf for claims for services provided to enrollees of plans. To proceed with an appeal, out-of-network providers must complete a Waiver of Liability using the form required by CMS or the state.	Out-of-network providers may use the integrated appeals process on their own behalf for claims for services provided to enrollees of plans. To proceed with an appeal, out-of-network providers must complete a Waiver of Liability using the form required by CMS or the state.	Out-of-network providers may use Medicare appeals process after completing a waiver of liability. See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 50.1.1.	No equivalent process.
Cases dismissed for late filing of Level 1 appeal without good cause	Plan does not automatically forward the case to the IAHO, the case is dismissed for being late without good cause, and the plan instead notifies the enrollee of appeal rights	Medicare process added in pending contract update	Plan does not automatically forward the case to the IRE, the case is dismissed for being late without good cause, and the plan instead notifies the enrollee of the right	No autoforward in Medicaid. An enrollee must make a request for a state fair hearing, to review the plan-level decision, in accordance with 42 CFR § 438.408(f).

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			to request an Independent Review Entity (IRE) review	
Opportunity to present evidence	The applicable integrated plan must provide the enrollee **a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments for integrated grievances, and integrated reconsiderations.** The applicable integrated plan must inform the enrollee of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe for appeals as specified in this section if the case is being considered under an expedited timeframe for the integrated grievance or integrated reconsideration. 42 CFR 422.629 (d)	Provide a **reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing,** see section 2.15.3.3.3 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. 2.15.3.5.3	According to 42 CFR § 422.586, the Medicare Advantage organization must provide the parties to the reconsideration with a **reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing.** In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore, the MA organization must inform the parties of the conditions for submitting the evidence.	According to 42 CFR § 438.406(b)(4), the plan must provide the enrollee a **reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.** The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.
Quality Improvement Organization (QIO) process	Remains the same as in Medicare managed care requirements, including required notices plans must use. See 42 C.F.R. §§	Remains the same as in Medicare managed care requirements. see three-way contract	Procedures under 42 C.F.R. §§ 422.620-422.622 apply.	Not applicable

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	422.620- 422.622 for applicable requirements	2.15.4.2, citing 42 C.F.R. §§ 422.620-422.626 for applicable requirements.		
Effectuation if the plan reverses its own initial decision in cases where the service or item was not provided while the appeal was pending	The plan must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires within 72 hours of the date it reverses the determination, or With the exception of a Part B drug, 30 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration (or no later than upon expiration of an extension described in § 422.633(f)); or (B) For a Part B drug, 7 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration. . See 42 CFR § 422.634(d)(1).	Plan must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than thirty (30) calendar days from the day Contractor receives the Appeal, or in the case of an expedited Appeal within seventy-two (72) hours, see three-way contract 2.15.3.5, 2.15.1.2.2, 2.15.3.5.5, and 2.11.5.6.2.5 Part B drugs: as expeditiously as the Enrollee's health condition requires, and within seven (7) days. see three-way contract 2.15.1.2	Reversals by the plan: **For standard service cases**: must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date the MA organization receives the request for reconsideration for non-payment cases, and **for requests for payment**: must pay for the service no later than 60 calendar days after the date the MA organization receives the request for reconsideration. 42 CFR § 422.618(a) **For expedited cases:**	The plan must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires within 72 hours of the date it reverses the determination. See 42 CFR § 438.424(a).

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			as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in 42 CFR § 422.590(e)). See 42 CFR § 422.619(a).	
Effectuation if the plans is reversed at Level 2 (State Hearing or IRE) in cases where the service or item was not provided while the appeal was pending	Plan must authorize or provide the disputed services in the timeframes described in 42 CFR § 422.634(d) (which cites to in 42 CFR §§ 422.618 and 619).	Governed by Medicare and Medicaid requirements: see next two columns	Reversals by the IRE: **For standard service cases**: must authorize the service under dispute within 72 hours from the date it receives notice reversi ng the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date for non-payment cases. **For requests for payment**:	Governed by 42 CFR § 438.424: MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

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			must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination, see 42 CFR § 422.618(b) **Expedited service cases:** MA organization must authorize the service within 72 hours from the date it receives notice reversing the determination, see 42 CFR § 619(b).	