VIII. Grievances – Participants shall be entitled to file internal grievances directly with the FIDA Plan either orally or in writing. Each FIDA Plan must track and resolve its grievances according to applicable Medicare and Medicaid rules, or if appropriate, reroute grievances to the coverage decision or appeals processes.

1. Grievance Filing Deadline. All grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident). Expedited grievance must be filed within 60 calendar days of the date of the coverage decision and must include physician certificate of need.

2. Acknowledgement of Grievance. The FIDA Plan must send written acknowledgement of the grievance to the Participant within 15 business 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 and Notification on Grievance. A FIDA Plan must respond to a Participant’s grievance as fast as the Participant’s condition requires, but no later than:
   a. Expedited: Paper review – decision and notification within 24 hours (in certain circumstances). For all other circumstances where a standard decision would significantly increase the risk to a Participant’s health, decision and notification within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance. Certain circumstances requiring a response within 24 hours are defined as:
      i. The complaint involves a FIDA Plan’s decision to invoke an extension relating to an organization determination.
      ii. The complaint involves a FIDA Plan’s refusal to grant a Participant’s request for an expedited organization determination under 42 CFR Part 422.570.
   b. Standard: Notification of decision within 30 calendar days of the FIDA Plan receiving the written or oral grievance.

4. Extension. Up to 14-calendar day extension. The FIDA Plan may extend the 30 calendar day timeframe by up to 14 calendar days if the Participant or provider on the Participant’s behalf (written or verbal) requests the extension or if the FIDA Plan justifies a need for additional information and documents how the delay is in the interest of the Participant. When the FIDA Plan extends the
deadline, it must immediately notify the Participant in writing of the reasons for the delay.

5. Notification of Grievance Decision. The FIDA Plan must notify the Participant of the decision by phone for expedited grievances and provide written notice of the decision within 3 business days of decision (expedited and standard).


IX. Appeals — Other than Medicare Part D appeals, which shall remain unchanged, the 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 acknowledgment.

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 of this appendix.

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 of this appendix. 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 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 III(a)(ii)(9)(a)and (b).

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.